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mental health digest

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cover story

Group Behavior

The hands on the cover illustrate some of the interactions that can take place between two or more people. Group behavior is the subject of several condensations in this issue of the *Digest*.

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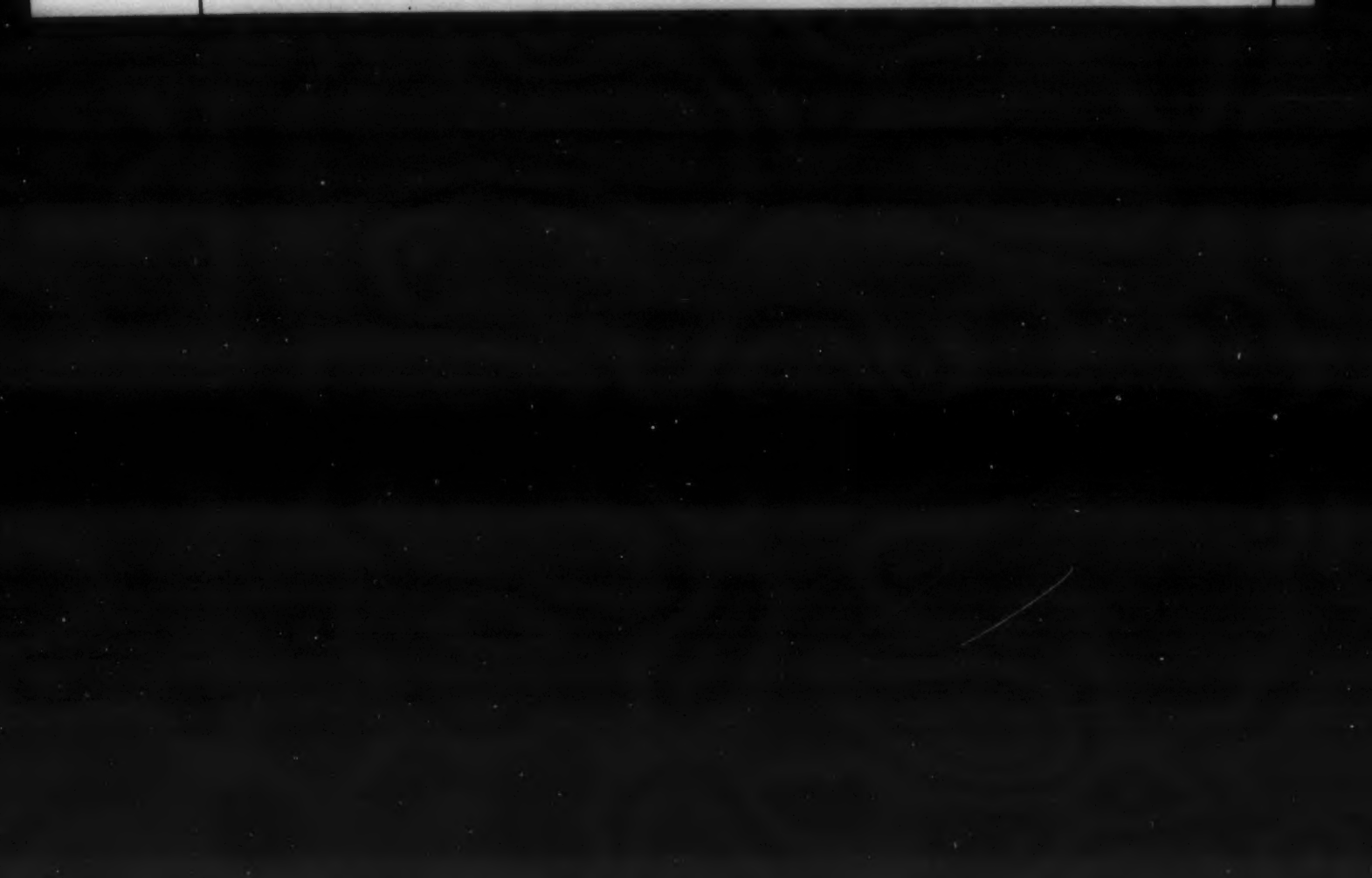

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The T-Group and Study Group Laboratory Experiences

Martin Harrow, Boris M. Astrachan, Gary J. Tucker, Edward B. Klein, and James C. Miller

During the last decade interest in training in group relations has increased enormously. One popular small group-training model is the T-Group, developed at the National Training Laboratories, which is based in part on social-psychological principles. Although there is diversity within the T-Group movement, some common goals are development of trust formation, increases in spontaneity and a freeing of inhibitions that have resulted from early social training, people learning how to become closer to one another, increasing one's sensitivity to oneself and to other people, and helping the group participants to "grow" and develop greater interpersonal competence. A contrasting type of small group is the Study Group, developed at the Tavistock Institute. This type is based on principles associated with the Kleinian psychoanalytic tradition. The two major goals are to develop a better understanding of covert group processes and to develop a better understanding of authority relations.

Both techniques seek to illuminate intragroup dynamics: The T-Group attempts to provide a setting in which primitive group processes may be modified under conditions of trust and exploration. The Study Group stresses the development of insight into dynamics, leaving the question of change open.

This research deals with process issues in relation to the goals of the T-Group and the Study Group. Data were collected on three questions:

Do group members view the leaders as behaving similarly or differently on key dimensions related to the theoretical goals?

Do participants view other members and the group in general as similar or different on key dimensions related to the goals?

Do members see themselves as behaving and feeling differently under these two group conditions?

The design involved two groups of students, each attending a five-session T-Group experience and a five-session Study-Group experience. The order of group experiences was counterbalanced with one group having a T-Group experience followed by a Study-Group experience with a different leader. The other group had a Study-Group experience followed by a T-Group experience with a different leader. Four experienced group-takers, two T-Group Trainers and two Study-Group Consultants participated, each conducting one group.

The subjects were informed that they would participate in a "small group experience," but were not told of the switchover of the leader or change in group style. The switchover occurred at the beginning of the sixth session when the former leader occupied the observer's chair (a silent and nonparticipating observer), and the former observer occupied a chair as a Study-Group Consultant or a T-Group Trainer. The subjects' verbalizations indicated surprise over the switch. The new group-takers behaved in the characteristic styles of Study-Group or T-Group Trainers. The subjects' first knowledge of the change was from their observations of the leader's behavior rather than by any announcement.

The subjects were students from a course in group dynamics and group psychotherapy. There were three med-

TABLE 1—*Major Areas Encompassed by Scales Used in the Semantic Differential*

Openness
Suspicious of others—Trusts others
Beats around bush—Frank
Evaluation-Gratifying
Frustrating—Satisfying
Pleasant—Unpleasant
Friendly—Not friendly
Emotional Expressiveness
Emotional—Unemotional
Expresses feelings—Feelings guarded
Closeness
Close—Distant
Rigid-Inhibiting
Flexible—Rigid
Noninhibiting—Inhibiting
Authoritarian—Nonauthoritarian
Strength-Influence
Influential in determining group members' behavior—Not influential in determining group members' behavior
Strong—Weak
Not powerful—Powerful
Knowledgeable
Superficial understanding—Deep understanding
Not aware of what's happening, "tuned out"—Aware of undercurrents, "tuned in"
Knowledgeable—Not knowledgeable
Evaluation-Respect
Worthless—Valuable
Respected—Not respected
Sensitivity
Understanding, sensitive to others' feelings—Lacks understanding, insensitive to others' feelings
Not particularly concerned with others' comments and behavior—Sensitive to others' comments and behavior

ical students, five nursing students (master's degree), six graduate students from the Administrative Sciences and the Sociology Departments, and five others. They were divided to obtain an equal sex ratio in the two groups, and an equal number from the same disciplines in each group.

The measure was a form of the Semantic Differential. After every session, all students rated pairs of bipolar adjectives and phrases, based on theoretical notions about T- and Study Groups. A list of the adjectives and the areas they encompass is presented in Table 1. The students rated each set of adjectives concerning their views of the following concepts: the group leader, other group members, the group as a whole, and themselves in the group.

Group Members' Views of the Trainers and Consultants

Overall, the results on the group members' views of the Trainers or Consultants were in accord with the way these leaders attempted to behave, and with theoretical expectations of what type of fantasies a leader will stimulate if he behaves in the style found among T-Group leaders or among Study-Group leaders.

The Study-Group leader's behavior stimulated fantasies (or realistic appraisals, depending upon how one wants to look at it) that he is an authoritarian and rather rigid figure who does not express emotion and who guards his feelings. Both of these sets of characteristics fit in with the model exemplified by the Consultant behaving in the Tavistock tradition, and both are, in general, in keeping with the model of behavior followed by traditional psychoanalysts.

In contrast, the T-Group Trainer's behavior seemed to stimulate a different view. The T-Group leader was seen as significantly less distant, and as more friendly, more pleasant, and less frustrating. These characteristics fit in with the more equalitarian and less inhibited atmosphere this approach wishes to establish.

Two other areas in which the group "leaders" attempted to establish certain atmospheres produced tendencies in the predicted direction. One concerns the T-Group leaders' emphasis on helping to foster a trusting and open atmosphere. There was a strong

trend in this direction, but the tests of significance were not conclusive. Similarly, the Study-Group Consultant attempts to engender an atmosphere in which he behaves as a neutral authority figure. There was a strong trend on the part of the members to view the S-Group Consultant as being more powerful, stronger, and more influential than the T-Group Consultant, but the results were not significant in every instance.

While the Trainers and Consultants were successful in stimulating the predicted atmosphere in most areas, there were two in which they were less successful. These involved views of the Trainers as being more sensitive to people and to their feelings than the Consultant, and views of the Consultant as being "deeper" and more aware of undercurrents in the group than is the Trainer. Thus, it could be hypothesized that the members would see the T-Group Trainer as more sensitive and understanding of the members' feelings and behavior. There was a very slight trend in this direction but the results were not significant.

We had anticipated that the S-Group Consultant's behavior might stimulate fantasies that he is a deep, knowledgeable, almost omnipotent authority figure. However, although S-Group leaders were relatively high on variables related to this factor, no significant differences were found.

Group Participants' Views of the "Other Members" and of the Group in General

The scores and tests of significance for the participants' ratings of "other members" and of the group are similar. The concepts overlap, and it was expected that most of the results for these two concepts would parallel each other. In general, the differences between groups were less significant than those for the views of the Consultants or Trainers. The importance of the leaders' behavior in establishing the unique group climate has sometimes been overlooked. Our data suggest that it is the leader and his behavior that exert the most crucial influence.

While the differences between members' views of the group were less significant than those between their views of the leaders, a number of powerful trends emerged, with most of these in the direction that would be predicted by theories about small groups. The T-Group participants tended to see the other group members, and the group in general, as being less rigid and less inhibiting, and this is one of the major goals of many T-Group Trainers. They also saw each other as more trusting and open, and as more satisfying and friendly. They tended to see the other members as being more sensitive to people and to their feelings, which is another key goal of many T-Group Trainers, and also saw the members and the group in general as closer.

A comparison of the data on the participants' perceptions of the other members and of the entire group with some of the other data indicates other interesting results. One important feature was that the climate fostered by the leaders carried over to the group in some areas, and in other areas produced the opposite type of feeling or attitude among the group members. Thus, the participants saw the Trainer as friendly, pleasant, and satisfying and, perhaps as a result of this view, they tended to see other members and the total group as being that way. Similarly, the group saw the Trainer as flexible and noninhibiting, and other members and the group in general, as behaving in that manner.

The T-Group's participants also perceived the Trainer as acting less distant and closer to the members and, perhaps partly as a result of this perception, the students felt closer to each other.

But there were areas in which the opposite relationship held. Although the members saw the Study-Group leader as strong, powerful, and a key factor in determining their behavior, there was a tendency to see the other members as weaker and less powerful. Closer analysis indicates that when the leader creates an emotional climate in which he is an active participant, the same climate often prevails in the group. But when the Consultant creates the impression that he is a powerful, influential figure, and when the group views him as depriving and as only peripherally within the group, group members may contrast his position with their felt inadequacy and impotence. This apparently infantilizes the participants, and they tend to see the other group members as weak, less powerful, and less influential. Our data suggest that T-Groups that attempt to emphasize competency in training do lead the members to see each other as being more powerful, which is consistent with the Trainer's attempts.

Group Members' Views of Themselves

Analysis of ratings on the basis of the members' overall views, as well as on a meeting-by-meeting basis, shows that there is no consistent pattern. More important, the members do not see themselves as different in the two types of conditions.

A meeting-by-meeting analysis indicates that members tend to see themselves as not changing over the 5 days, but preliminary examination indicates that views of the Trainer, others, and group as a whole do change. Thus the individual members view themselves as influenced less than other members were. Since they do tend to see the other members and the group in general as influenced by the type of group, some self-deception may be present.

Other alternatives are possible. These results may bear on the issue of self-change. At present the evidence on changes in the way a person views himself as a result of training group experience is mixed. Our results could be interpreted as suggesting that in training groups of relatively short duration a member's perception of self is not likely to show significant changes.

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The Personalities of Group Leaders: Implications for Selection and Training

Beryce W. MacLennan

Only in recent years has there begun to be serious study of the personality and life experiences of group leaders and their implications for the capacity of individuals to run counseling, growth, and therapy groups.

In the early days of group psychotherapy and counseling, the assumption was that if an individual had professional training and supervised experience, and had the inclination, he/she would be able to run a group. There was unspoken recognition that some people could not learn how to manage groups or were not able to work with some populations, but lack of knowledge of the dimensions of these problems made most of us reluctant to tackle them. Two recent developments have made it urgent to attempt to deal with this issue: One is the New Careers idea, and the proposition which states that unless you are drawn from a population similar to the group members, and/or have undergone similar experiences, you cannot assist them. The other is the idea, prevalent among many growth encounterers if not their leaders, that anyone who has had a group experience is fit to lead a group.

Different Leadership Qualities for Different Groups

One study of the traits of leaders concluded that leadership qualities varied with the composition and goals of the group and the functions required of the leaders. I think that this is true for leaders of counseling, therapy, and growth groups; and that who the group members are, what their goals are, and how they will go about achieving them will affect what kind of personality, life experiences, and skills the leader must have to lead the group successfully.

But how do we judge success? Sometimes it is on the sayso of the leader or of the members, sometimes on the basis of changed behaviors, sometimes merely on what occurs in the group—members attend, group goes according to plan, happenings in the group seem relevant—sometimes on the lack of serious crises experienced by members. Success actually should be related to goals and, whenever possible, to changes in real-life behavior.

A leader may be expected to play a variety of roles and perform a number of functions in a human-relations group, depending on the goals of the group, the needs of the members, and the philosophy of the leader. Goals may be related to problem solving, self-development, therapeutic reconstruction, or training. Members may be students, patients, trainees, clients, or more vaguely "participants." The leader may be a source of information or a creator of linkage, essentially a resource person and facilitator. He may function as an understander, clarifier, interpreter of feelings and needs. He may take the role of benevolent authority, a setter of limits, a confronter with reality, possibly a source of support, and a structurer of situations which permit freedom of expression within safe limits. The leader may be an authority who understands and accepts members, their actions and feelings without censure or blame, and who thus reduces guilt and enhances self-esteem; a director who structures experience for success

or confrontation or learning; a model for identification who may represent the ideal in a particular culture; a parent or authority whom members emulate; a more successful peer who has shared the same experiences and problems, and who represents a value system; or an individual who also has problems and is willing to share his feelings and reactions as honestly as he can. A leader may be a transference figure enabling members to re-experience and understand problems from the past that interfere with the present, or an expert who understands resistances, games, and coping mechanisms, and helps group members understand individual and group patterns of behavior.

The role that is adopted seems dependent on the needs of the members, on the change philosophy of the leader, and on his/her temperament and self concept.

If we examine the requirements of some of these roles, we find them to be contradictory. A benevolent authority cannot at the same time be a peer. An active confronter behaves differently from a leader who deliberately keeps his personality rather vague. A leader who creates experiences of success for members through group structure, exercises, and games, behaves differently from a leader who works through lack of structure and the evolution of the group process or who believes in total spontaneity.

Professional Group Therapists

While there are some common attributes, we find that there also are different qualities and role perceptions described by different leaders. Some leaders see themselves consistently in one role. Others appear to vary their roles in accordance with the demands of the group. Some of the skills and personality characteristics which most professional group psychotherapists expect to acquire in their training include:

Capacity to listen to and understand the underlying feelings, themes, and defensive operations which go on in groups.

Capacity to understand and manage group operations at the level planned.

To be accepted as a leader.

To be responsive and empathic.

To perceive and manage self without interference from inner pressures.

To be responsible.

To know how to help individuals and group clarify attitudes, feelings, and values, and to perceive their behavior as others see it.

To be able to judge the level of pressure that groups and individuals can accept and to be able to control the level.

To know how to stimulate member interaction.

Leaders are generally described as experts. They vary in the degree to which they are active in the group, the degree to which they will deal with their own problem, the degree to which they structure the group and their own roles, and the level of control and ambiguity which they promote.

Nonprofessionals

Programs employing indigenous workers have been more concerned with the personality qualities and life experiences of candidates. Indigenous nonprofessionals are by definition thought of as peer group leaders. They are considered to be successful examples and models for the members with whom they work. Successful leaders know and understand the culture and the normative behavior and values of their population. They are accepted as leaders by their people

and can speak to them in a language and style which is compatible with the culture. They have had direct experience with the problems of members and can assist in finding solutions to problems which are in tune with the reality of the group member's existence. They can distinguish excuses and resistances from the real difficulties which members have to face, and stand up to the challenges of group members. They have met and overcome a number of difficulties themselves. They can empathize without overidentifying with or rejecting a member and his/her problems. They are perceptive, self-aware, and able to control their own problems. They are responsible and reliable. Although not usually stated, a reasonably high level of intelligence is implied. The best leaders have high energy and organizing ability. They are able to communicate across systems and have some knowledge and understanding of the dominant culture, and its values and expectations. They are accepted as facilitators across cultures. They care for their group members.

Common Qualities

We must also ask how we can select leaders for different kinds of groups, or whether leaders are, in fact, self-selected. Are there some qualities which are true for all group leaders?

Some supporters of the helper principle and the indigenous worker assert that true empathy, that is, the understanding of how the person is feeling and experiencing at a particular time, can only be acquired through common experience. To follow this argument to the extreme, one would have to be the other person truly to empathize. It is my belief that one learns to increase one's empathic capacities through one's own experiences, the experiences of others, patients, colleagues, books, films, friends, and through the exercise and testing of one's imagination and perceptions, through being a good listener, and through being able to draw out of the group member, with the assistance of other group members, a vivid description of the member's situations and feelings about it. Some capacity for introspection is essential. The range of a leader's capacity to empathize grows with his/her experience and his/her ability to refrain from taking a personal and self-involved position. The leader will grow more comfortable with different kinds of people as his/her knowledge and experience grows. His/her capacity to work with special populations can also be enhanced by studying the culture, the value systems, the language, and by being exposed to the perspective of members of that group. The leader must know that individuals vary greatly within the culture and be able to distinguish between the norm for that group and the individual's reactions to it.

Qualities for Different Levels of Group Operation

The life stage of the individual leader—Relatively undiscussed elements which are probably of considerable importance in leader choice and capacity to work with particular groups are the life stage of the leader and his/her values and qualities in relation to that stage. Has he/she dealt with the developmental and moral problems which the population is facing? Are the leader's values compatible with those of the population; can he/she empathize with the problems and struggles of that population? Does she/he possess personality qualities acceptable to that group? To what extent do the leader's life ex-

periences assist or hinder capacity to work with particular populations?

It is possible for leaders to have great understanding and empathy for one age group and not for another. Many leaders, for instance, are reluctant to work with the elderly because they have not themselves faced the problems in growing old, or because they feel that old people can no longer grow and develop. Other leaders find the challenge and pressure of adolescent groups too hard for them to sustain, yet may work well with younger children or some adult groups. Young workers often find it easier to work with their own sex or with children when they first start. Many initially have problems in assisting married couples or parents because they have not yet had experience in these roles. Effective group leaders develop over time a wide-range learning both from their own life experiences and from the group members with whom they work.

Personality and group member needs—A second question is whether the personality of the leader and the group atmosphere she/he creates will be effective for the group members with whom she/he is working. This question is raised particularly in groups that aim for attitude or character change (whether growth or therapeutic, rather than the more superficial solving of specific problems or understanding of alternatives.

It is generally agreed that leaders need to understand their own attitudes and feelings about the group members and the subject matter dealt with in the groups. More intense groups place greater demands on leaders. It is harder for them to keep from acting out and to maintain self-awareness, and an adequate perception of reality. True spontaneity, which is perceptive, task- and reality-related, is only achieved after a high level of training. Consequently, these groups should not be led by neophytes.

It has been observed that beginning students of counseling, social work, and psychotherapy, who have relatively little skill but are highly concerned and caring, achieve excellent results with patients or clients who require an enhancement of self-esteem, the support of someone who will care and listen, particularly in the midst of crisis, and who is able to assist in reducing the pressures of the environment. They achieve less with complicated neurotic problems where group members are highly ambivalent. Many professionals become overconcerned with theory, method, and techniques, and lose the fresh warmth and concern of the novice. This seems to me to be a defect of the training rather than an argument *against* training.

Some of the most charismatic, visible, and well-known professional therapists tend to be quite narcissistic people about whose effectiveness and sense of responsibility there is no general agreement among colleagues. At present, there is no accepted way of addressing this possibly quite destructive factor. It seems likely that many group members are able to respond to warmth, empathy, etc., and that this support and understanding help them to work out their problems. Some group members require highly emotive groups to "unfreeze" them, and some need to be firmly confronted with their own manipulations. It is also true that some patients cannot tolerate high emotionality and warmth because of the fears which are aroused, and that other neurotic patients have complicated, ambivalent responses which require skillful and longer-term treatment to understand and to change.

From my experience as a therapist and supervisor, I know that each of us has more difficulty in responding to one kind of patient than another. I have watched a therapist excellent in other ways be unable to cope with highly aggressive male group members, and another who could not feel any hope that an unmarried older woman could lead a happy and satisfying life. The more a group leader knows about him/herself, the more he/she can learn to overcome these problems and biases. However, it is essential that any group leader be willing to accept his own current limitations and to work to overcome them.

Cultural and Class Similarities and Differences, and Acceptability of Leader

This problem includes not just the leader's capacity to empathize, but also his/her acceptance by the group as being able to understand and relate to the members' situations in a relevant way. Nonacceptance may be a resistance which can be overcome, but there may be so great a support for stereotyping in the climate of the day, that too great a difference between the life situation of the leader and the members will prevent his/her acceptance as the group leader. This problem is likely to be enhanced in homogeneous groups with a wide difference between the leader and the members. In heterogeneous groups concerned with character change, it seems relatively easy to help group members understand each other's essential humanness. In fact, the heterogeneity of the group may make it easier to identify common dynamic problems, and, of course, allows much greater latitude with regard to the leader's background, while demanding greater skill.

Selection of Leaders

In most professional group psychotherapy training programs, an assumption has been made that individuals who have been admitted into individual psychotherapy training and who are interested in groups will be able to perform effectively as group psychotherapists. The criteria for acceptance into the professional training programs are usually unclear; and major weaknesses remain in regard to techniques of selection and unclarity about the personality qualities which are to be selected.

What, then, does this discussion suggest for the selection and training of group leaders?

There are some general personality characteristics which are important in the selection of all leaders of counseling, therapy, and growth groups. Potential leaders should be concerned and care about others. They should be able to care about and accept the individual as a human being even when they feel that the individual's behavior is destructive to himself and others. They should, even in the beginning, give evidence of being intrapsychically aware and interpersonally perceptive, and have some natural ability to perceive what is going on between people without excessive distortion. They should be interested in human relations. They must be open enough to be willing to learn more about themselves and to deal with their own problems. They should have shown some leadership ability with a group, be accepted, trusted, have good judgment, have some capacity to accept responsibility, and be able to stand firm in the face of challenge, though not necessarily in an aggressive way. They have to learn to deal with in-

stability, ambiguity, and change in their own lives and in the group.

Education and training, it seems to me, should be directed toward enhancing the leader's range of understanding of a wide variety of human situations and dilemmas—how people live and how they deal with problems; to be able to listen accurately and to respond in terms of the individual's perspective; to know what alternative solutions and resources are available in the culture with which one will work, to strive to gain greater understanding, acceptance, security with one's self, and to increase one's own capacity to enjoy life. This involves broadening experiences both in supervised work and in one's own life, and working with others in increasing one's sensitivity, understanding, and perceptiveness of all kinds of situations. Such an approach pervades all areas of a leader's life: studies, cultural and recreational experiences, intimate life, as well as work.

This approach to selection and training has little in common with the higher educational system of the present. Furthermore, professional compartmentalization into discrete disciplines is not designed to serve the public but to create vested interests which support the economic and hierarchical status of the professional. To some extent, academic and professional training is also designed and required of trainees in order to support the personal idiosyncracies of the professors and the financial requirements of universities. So long as we retain this traditional system of higher education and professional training, it is impossible consistently to select, develop, and utilize effectively relevant and competent group leaders who can assist group members to grow, live satisfyingly, and cope with their problems.

The first implication of these developments is for us as professional mental health specialists and group leaders to reassess ourselves and the system we sustain.

The second implication is seriously to address what is known and what we need to know about the methodology of selecting group leaders in terms of their personality characteristics.

The third implication is to consider how we can develop a functional system for the continuous efficient utilization, development, and advancement of group leaders in human services.

Condensed from a paper presented at the Annual Meeting of the American Group Psychotherapy Association, Inc., New York, N.Y., February 10, 1972.

Reprints of original article from Beryce W. MacLennan, Ph.D., Acting Chief, Mental Health Study Center, 2340 University Boulevard East, Adelphi, Md. 20783.

Group Therapy: What Specific Therapeutic Advantages?

Jonathan A. Guttmacher and Lee Birk

In recent years there has been a growing appreciation of the value of group therapy. It has become less common for a patient to be referred to a group because he can't afford the high fees of individual therapy or because he is felt incapable of gaining real insight and growth, and thus is relegated to a therapy which is felt to be supportive, at times almost caretaking. This paper describes some aspects of therapy which are peculiar to groups, or which may be effective in the group setting. It is almost a truism that group therapy is helpful in terms of relief from isolation, realization that others share problems, and relief of unrealistic shame. We mean to talk about other aspects of group therapy less commonly focused on.

Problems Displayed in Vivo

Conflicts and maladaptive social response patterns in group therapy are exhibited in vivo, in the therapist's presence, rather than retrospectively narrated. This allows for direct observation of the patient's behavior, his perception of situations, and expression of feelings, permitting explicit diagnosis of his interpersonal needs and problems, and setting the stage for the therapist and other group members to intervene directly in repetitive maladaptive social behavioral sequences.

Therapeutic Leverage for Egosyntonic Problems

"Character disorders" (personality disorders) are difficult to treat because of their ego syntonic quality. Group therapy can often provide leverage toward change because in many clinical situations there are subtle characterological problems with a clear egosyntonic quality. Often the patient does not feel he has a problem. The primary discomfort is not felt internally; instead the problem is felt to exist within the environment. In individual therapy such problems can be difficult to confront because the patient does not come with anxiety about his behavior and a wish to change it. In the group setting, his behavior can be faced more squarely. The patient cannot be evasive because his actions are directly observed, and his distorted views can be challenged by other group members and the therapist(s).

In a group we have led, a young woman told of situations in which she had been hurt by her father and other men, and how she was fearful of men. This was true, but what she failed to reveal was how furious she was with men, and how provocative she was in eliciting anger. When she began to form a relationship with a man in the group, she revealed the intensity of her anger and provocation. When she felt the impact of her feelings and behavior, she experienced anxiety about her difficulties and was more motivated to do something about them.

Thus, with the realization of behavior or feelings, the egosyntonic veneer begins to disappear, and the underlying distress becomes more apparent leading to anxiety and a desire for change. This occurs in skilled individual therapy, but the chances of it being done in such a way as to be apparent and useful to the patient are less.

Multiple Transferences

Other group members elicit a multiplicity of transference feelings: Sibling, parental, oedipal, and other

feelings from the past. In a group in which we served as cotherapists, strong ambivalent feelings toward the male parent were expressed by two group members. They tended to polarize these feelings between the therapists, one being the object of positive feelings, the other the object of negative feelings. The experiencing of ambivalence in such a direct here-and-now way provides an unusual opportunity to focus on and clarify these feelings. With male-female cotherapists, our experience is that transference material in relation to each parent comes to the fore more easily than in the one-to-one therapeutic situation.

Our experience has been that transference feelings are more intense in the group situation. Our experience, moreover, has been that intense positive and negative transference feelings tend to be better tolerated and more freely expressed in a group. This may be related to a feeling of greater safety because others are present.

"Abstinence" and Therapeutic Frustration

For many patients not only is intensity of transference feelings increased, but the frustration of transference wishes is heightened. In individual treatment the component of "abstinence" is limited by the nature of the therapy itself. In group treatment, since each member cannot have the therapist to himself, the therapeutic situation produces a greater component of abstinence with respect to this wish. It is with just those patients, who are so difficult in individual therapy because the transference relationship is in a sense "locked-in," gratifying and lacking in anxiety to the patient and thus not open to examination, that group therapy is helpful.

A type of patient in which this is of particular importance is the passive, dependent, depressed woman. This type of person often does poorly in individual treatment because she utilizes therapy as another instance of clinging and hanging on, with no motivation to tackle her problems. To her, therapy is one of many attempts to seek attention and nurturance. In the group situation the attention of the therapist to the patient is lessened, and his interest has to be shared with others; for this reason the frustration of dependency desires becomes apparent, with a resultant increase in anxiety, allowing real psychotherapeutic work to be done.

A married mother of three with psychosomatic complaints, periods of minimal functioning, and obsessive concerns about her children, made no progress in individual therapy. She opposed the transfer from individual therapy to group, attempted to maintain individual therapy with her old therapist, and to initiate individual sessions with her new therapist. When these attempts were frustrated, she settled into the group and through the reality testing which her peers insisted on, began to see the excessive nature of her demands and her need to manipulate others. The group members became angry with her. She was hurt, angry, mortified, but despite this she remained, and came to see how she provoked such anger and how insistent she was on remaining dependent. With this awareness, she started to give up her lifelong, passive-dependent, passive-aggressive style of coping. She obtained a driver's license after years of not being able to take a driver's test, got a part-time job, joined her husband in buying a house, and dropped the obsessive concerns about her children.

Identification and Reality Testing

It might be argued that in a group the imposition of reality inhibits the arousal and expression of transference feelings. This can happen if the true characteristics of the person to whom the feelings are directed im-

pede the projection of the patient's fantasied feelings, as may occur in individual therapy. The other side of this is that reality can encourage the production of transference feelings if the object has characteristics similar to those of a person who has played an important role in the patient's early years, and who has been the object of the patient's ambivalent feelings. The skillful group therapist can help group members discern which are realistic reactions, and which are distorted and presumably based on transference. This is the task the patient needs to do in daily life. Thus, the group is an excellent setting for reality testing, and for learning to discern whether feelings are appropriate or not. Often the intensity of feelings suggests their transference origin although qualitatively they may be appropriate to the situation.

Identification is enhanced in the group by the opportunity to see the therapist more as a real person, rather than as a stereotyped or shadowy figure. Greater pressure is exerted on him to interact and reveal his qualities as a real individual, relating with others in a complex interpersonal situation of a more natural kind than that of individual therapy. This allows the opportunity to see that everyone is not made in the same mold as parental or other important childhood figures. An example is a man who was in many ways frightened and inhibited, but also passive-aggressive, owing to his relationship with a hostile, vindictive father. When two other patients struck up a romantic relationship, he was amazed that the two therapists did not take a punitive stand or prohibit the relationship, but only made it clear that this relationship would be open to group scrutiny. Such an approach is not unique to group therapy, but in the group situation, the patient saw that the therapists were not paying lip service to such a stand, but through their actions showed they did not have punitive angry feelings about the relationship. This sort of experience aids in making the therapist a more human figure, not so remote, and thus easier to identify with. Although the therapist is revealed as a more "human" individual in the group setting, his role is not that of a friendly counselor or advisor. A major portion of his role is to be the figure who provides a certain amount of anxiety and frustration by not meeting every demand and wish of group members.

Group Members as Role Models

The presence of other patients promotes partial identification with other individuals. A patient tends to identify with those traits, styles, and attitudes of other members which are more attractive or effective than his own. Group members tend to have different liabilities and assets; patients can and do use each other as positive role models.

They also use each other as negative role models. Often through observing someone else, the patient sees a caricature of what he does, and why his methods of relating are ineffective or antagonize others. This can be thought of as the inverse of identification; it is the opportunity to become aware of one's own unattractive patterns, to see the effect they have on others, and become motivated to change them.

The occurrence of such role modeling and experimentation with new modes of social behavior allows the patient to see that expressing certain feelings or attitudes will not bring about the reaction he had

feared; for example, showing anger will not bring rejection. He will try out such new approaches, because the group is seen as a place where mistakes can be made without the repercussions that might result in other settings.

The Iceberg Phenomenon

In groups, patients often get dramatically better through work that is silent and out of view. There are people who say little but are intently absorbed in what is going on, and after months in therapy will report changes in their lives.

Two women who were in treatment participated verbally, but in terms of content did not appear to be working out important issues. Within a year both were able to establish a new kind of relationship with a man. Each became involved on a more meaningful, intimate, and trusting level than had been possible previously. Although each of them had touched on some aspects of their unsuccessful relationships with men, there had been no working through of the issues. Yet major change occurred in both women. Both patients commented on their increased ease with people and capacity for closeness, and felt this was related to their experience in the group.

In our experience, the iceberg phenomenon seems to apply mostly to nonpsychotic patients, presumably because they are more capable of profiting from exposure to new kinds of object relationships experienced in the group. For borderline patients and those with a psychotic history, progress appears to be more related to working out issues.

New Objects and Long-Term Social Learning

Some very sick patients appear to make strides in terms of forming, for the first time, meaningful object relationships within the group. In the group, after several years of therapy they show greater openness and trust, and empathy and closeness to other members. Gradually they cope much better when confronted by stresses from within the group, but in their lives outside the group such patients change at a slower pace, in a way that is almost the antithesis of the dramatic improvement in patients described as examples of the iceberg phenomenon.

Within the group, one chronic schizophrenic man was a very real person and valued member, but outside he remained isolated. His out-of-group friendships increased in number and depth but at a slow pace. He was able to go back to school, but this took several years to accomplish and was accompanied by many crises. Within the group his genuine feelings, insight, and concern for others were typically very impressive. But the expression of these feelings outside the group was difficult, and what was accomplished was extremely slow, especially compared to the two patients cited as examples of the iceberg phenomenon.

These patients have formed important relationships within the group, and outside the group after long treatment they have begun to show some improvement in their personal relationships, mostly at work. How far this can go with continued treatment is not clear. It is important to remember that in group therapy, as in individual therapy, psychoanalysis, and sensitivity training, the subjective therapeutic experience can be real, human, and affectively intense without necessarily leading to real therapeutic change.

Cohesion as Catalyst

The feeling of acceptance, cohesion, and sense of belonging which develops in a group therapeutically engaged often enables patients to work on issues they could not really grapple with in individual therapy, or to withstand a degree of anxiety that would cause them to flee from in-

dividual treatment.

Acceptance among members in a therapeutic group has a special quality about it, not to be equated with one person liking another. Very often group members will be antagonistic but feel that each is very much a part of the group. It is as if at last there is a setting in which a facade of strength, compatibility, accomplishment, or passive accommodation is not necessary to prevent derision, rejection, or banishment.

Acceptance leads to a strong sense of cohesion, a feeling of belonging to something special, a growing sense of importance, status, and self-esteem. With it, patients often are able to confront problems and withstand a degree of anxiety which would make them flee individual therapy.

Peer Interpretations

The observations and criticisms of peers are often given much greater credence than those of a therapist. This is true for all effectively working groups, but particularly true for homogeneous groups of personality disorders where the environment or other individuals are blamed for problems.

An individual therapist's remarks at times may be viewed as platitudes pulled from his store of professional cliches for every therapeutic occasion, or his remarks may be seen as manipulative, not a genuine reaction but an attempt to aid in bringing about a desired therapeutic goal. What a therapist says often has a much greater effect when it is seconded by group members, or even better, when he is in the position of seconding interpretations by the group.

Another kind of advantage can occur when a group member disagrees with the therapist. The therapist's remarks then take on a human quality, so that they can be given serious consideration, rather than be received as authoritarian pontifical statements.

Therapists may at times arrive at a thoroughly wrong understanding of a case and then pursue their mistaken idea more or less unchecked. In individual therapy, the patient may have great difficulty in opposing the therapist because of his dependence on him and the therapist's armor of professionalism, experience, and, presumably, greater knowledge. The group can provide an important check against erroneous interpretations by the therapist.

Thus, the group setting engenders an atmosphere which at times can be more conducive than individual therapy to confronting the issues and feelings and in which the patient may be more receptive to observation and criticism made by the therapist and other group members.

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Group Risk-Taking Under Various Group Decision Schemes

Robert B. Zajonc, Robert J. Wolosin, and Myrna A. Wolosin

In studies of group decisionmaking it is often found that group choice differs from the average of the individual members' choices. This is especially true of studies on decisions made under uncertainty which involve risk. Normally, in these studies, first observed are choices of single individuals, who are then formed into groups for the purpose of coming to a joint decision. These decisions often seem to be at variance with the average of individual decisions.

Two components of the difference between individual and group choices were previously distinguished. First, it is possible that individual choice preferences change when people act in groups. In fact, theories which attempt to explain the "risky shift" phenomenon limit themselves to this component factor and seek to isolate its causes. One theory holds that in groups responsibility for the decision can be diffused among the individuals; others hold that the group provides the individuals with knowledge about cultural values regarding the alternatives; or that he becomes more familiar with the decision problem; or that some members are more influential than others. Each of these theories assumes that if there is a change from individual to group decisionmaking, something happens to individual preferences for the choice alternatives when the choices are made jointly and in a group setting.

The second component focuses on the ways in which individual choices are combined to form a joint decision. A difference between the average of individual choices and the joint decision can be obtained without any change in individual preferences.

In studies on risky shift these two components of the discrepancy between individual and group choices are allowed to vary simultaneously and are confounded. If change does occur, it is impossible to determine whether it occured because of changes in individual choice preferences, because a particular decision scheme is adopted, or because of an interplay between the two components.

The purpose of this study is to examine whether changes in individual choice preferences occur in groups when group decision schemes are controlled. A second purpose is to provide validation for a model of group decisionmaking under risk. This parameter-free model was previously tested for two-choice situations with event probabilities of .6–.4 and .8–.2. It is of interest to determine whether the model represents a viable approach to the problem of group decisions by examining it under a new set of event probabilities, namely .67–.33.

Ninety-six male undergraduates, recruited from a paid psychology subject pool, were assigned randomly to four experimental groups. Two lights, mounted on a small panel, signaled stimulus events. One was marked "1 cent," and the other "2 cents." For half the subjects, the left stimulus light was associated with the high payoff (and hence low probability of occurrence), and for the remainder, with the low payoff (and high probability of occurrence). All subjects were given 360 trials in two sets of 180 each. The stimuli were programed with .67 and .33 probabili-

ties of occurence. The sequence of stimuli was random with the constraint that these probabilities be observed within each block of 30 trials.

Upon arriving at the laboratory, subjects were taken to cubicles where they worked alone for the first 180 trials. Taped instructions were given over an intercom:

In front of you, you see two lights. Every 7 seconds one or the other will come on. You also see two response plates. During each 7-second interval, you are to press one plate or the other to anticipate which light will come on. If you press the left plate and the left light comes on, you win 1 cent (2 cents). If you press the right plate and the right light comes on, you win 2 cents (1 cent). If you press one plate and the opposite light comes on, you win nothing. Also, if you fail to press within the 7-second interval you win nothing.

You can keep track of your winnings with the chips in front of you. If you win 1 cent by anticipating the left (right) light, place a white chip into your bank. If you win 2 cents by anticipating the right (left, light, place a blue chip into your bank. You are guaranteed a minimum of $1.25/hr. and you may keep whatever you win over that amount.

The second set of 180 trials differed.

Individual-Individual—At the end of the 180 trials subjects in the Individual-Individual treatment were taken out of the cubicles and allowed to relax for about 3 minutes but were not permitted to speak to one another. After the rest period, they were taken back to their cubicles and they continued for another 180 trials.

In the remaining treatments subjects worked in groups of three.

Individual-Majority Vote (I-M)—Subjects in the Individual-Majority Vote treatment were told that the first part of the experiment was over. All three subjects were led to a room with apparatus identical to that which they had used alone. Taped instructions were issued:

Again you see the lights and the plates. Now you are working as a team making decisions as a group. This time, you will raise your hand so that everyone of you can see what the others have chosen. If you decide on the left light, press the left plate and raise your left hand. If you choose the right light, press the right plate and raise your right hand.

I will now tell you how your individual decisions combine to make a group decision. The light which is chosen by at least two of you is your group decision.

If your group decision is for left and the left light comes on, *each* of you wins 1 cent (2 cents). If your group decision is for the right, and the right light comes on, *each* of you wins 2 cents (1 cent). If your group decision is for one light and the other comes on, *each* of you wins nothing. Each man's pay during this group session depends on the group's decisions.

Individual-Minimum Quorum (I-MQ)—After subjects were ushered into their group room, instructions similar to those from the I-M treatment were played, with the appropriate changes as follows:

I will now tell you how your individual decisions combine to make a group decision. If all three of you choose the left light, then the left light is your group decision. If at least one of you chooses the right light, then your group decision is for right. In other words, the only way for your group decision to be for the left light is if all three of you choose left.

In this treatment, the group choice was for the risky alternative when any one of the three group members made such a vote. A conservative group choice could occur, therefore, only when all members voted the conservative alternative.

Individual-Unanimity—In the Individual-Unanimity treatment (I-U), instructions were modified to communicate that the group could make a risky choice if, and only if, all three members voted for the infrequent alternative.

In each of the group conditions 180 trials separated by 15-second intervals were given. As previously, the

probabilities were ⅔ and ⅓, and they were observed for each block of 30 trials The subjects were not permitted to discuss their choices, and they were required to vote at the same time.

Individual and Group Choices

Results are reported in percentages of risky choices. All groups showed declines in risk-taking (i.e., shifts in the conservative direction). The smallest decline occurred in the I-MQ treatment, while the largest decline was shown by I-U groups.

Group Decision Schemes

It will be of interest to examine the present data in the light of the decision model. This parameter-free model assumes that, given two alternative events, A and B, occurring with the probabilities $p(A)$ and $p(B)$ with $p(A) > p(B)$, the individual can find himself at the onset of any trial in any of three mutually exclusive states: He is certain that A will occur and equally certain that B will not occur; he is certain that B will occur and equally certain that A will not occur; he is uncertain which of the two events will occur. These three states can be called A, B, and AUB. An individual's probability of being in a given state is assumed to correspond to the objective probability of the given event. For example, his probability of being in state A, P(A), is equal to the probability that A will occur times the probability that B will not occur; his probability of being in state B, P(B), is the converse; and his probability of being in state AUB, P(AUB), is the remainder. For the .67–.33 event probabilities

$$P(A) = p(A)[(1-p(B)] = .44;$$
$$P(B) = p(B)[(1-p(A)] = .11;$$

and

$$P(AUB) = 1 - P(A) + P(B) = .45.$$

Subjects are required to predict either A or B and cannot declare uncertainty. Hence, states A and B are stable, and when in these states the individual will make the response "A" or "B," respectively, before the trial terminates. But AUB is unstable, and the rules of the experiment require him to move from AUB to another of two states, A or B. It is thus assumed that the individual who is in state AUB at the onset of the trial will move to A or to B. The probabilities of moving to A or to B from AUB are not proportional to the probabilities associated with the events A or B, but they are proportional to the payoffs associated with these events. Hence, in the present case the individual who is in AUB will move twice as often to B than to A because the payoff for B is 2 cents and for A only 1 cent. In this experiment the model predicts 40.7 percent risky (i.e., B) choices when they are made individually. Actually, in the last 90 trials of the first session, which represent individual asymptotic performance, there were 41.7, 44.9, 44.5, and 42.9 percent risky choices for the I-M, I-U, I-MQ, and I-I treatments, respectively. These values average to 43.5 percent risky choices, a figure not too far removed from that predicted by the model.

According to the decision rules required in the I-MQ and I-U treatments the model would predict $1-.593^3 = .792$ risky choices in the I-MQ treatment and $.407^3 = .067$ risky choices in the I-U treatment. For the I-M treatment we would predict that the group makes a risky choice when either all three group members are in state B (equal to .067) or when two of them are in state B and one in state A (equal to .296). Hence, the probability that the group will choose the risky alternative when operating under the ma-

jority rule is predicted to be .363.

This last figure is close to the one obtained in the I-M treatment, namely .39. A conservative shift is predicted by the model when the group operates by the majority rule, and such a shift is obtained. The predictions for the I-MQ and I-U treatments, however, are utterly incorrect. The predicted probability of risky choices of .792 *overestimates* the I-MQ performance by nearly 40 points, and the predicted probability of .067 risky choices *underestimates* the obtained performance of I-U groups by nearly 30 points.

How can these discrepancies be explained? Two possibilities exist. We can assume that individual choice preferences remain stable when subjects move from the alone condition to groups operating under the majority rule. But they change dramatically when individuals move to groups operating under unanimity or quorum. This conjecture is contradicted by the evidence. There is indeed a drop in risky choices for individuals going into I-MQ groups, but the change is negligible for individuals joining I-U groups. Moreover, the drop in individual risk-taking in the I-MQ treatment is not sufficient to explain the obtained results. Since 33.2 percent of individual choices are risky choices, we would expect in the I-MQ condition $1-(1-.332)^3=.702$ such group choices. This figure is somewhat smaller than the .792 predicted by the initial probabilities but out of the range of the data.

The answer must lie in the frequencies with which the various combinations of individual choices occur in the group setting. There are four such group states, AAA, AAB, ABB, and BBB, where each letter represents the terminal state in which one of the group members finds himself on the given trial. We assumed that the individuals make their decisions independently of others when in groups, and this assumption was tenable for previous experiments on individual and group risk-taking and for the present I-M treatment, and even if it was not tenable, the predictions made under this assumption were not far from the observed results. But it is not tenable for the I-U and I-MQ treatments.

There are striking departures from the expected probabilities in the I-U and I-MQ treatments in the direction of increased occurrence of unanimities. The model predicts that there would be 27 percent unanimities, 20 percent favoring the frequent and 7 percent favoring the infrequent alternative. In the I-M treatment there is a tendency for these unanimities to be somewhat larger. However, in the I-U and I-MQ treatments these unanimities occur with an overwhelming frequency. In the I-U groups we have 84 percent, and in I-MQ we have 83 percent unanimities, which are far above the expected percentages. The unanimities in the I-U groups favor the risky alternative more than they do in the I-MQ groups. It is in this manner that the groups can maintain a level of risk-taking which the individual members consider acceptable, and which do not require the individuals drastically to change their own choice preferences.

To summarize, the individual who finds himself a part of a joint decision team does not seem to abandon his idiosyncratic preferences. Nor is he ready to allow the group of which he is a member to make decisions which would deviate significantly from his own preferences. This seems

to be the case where this is quite difficult as, for instance, in groups that operate under the unanimity rule. The individual solves his problems by a judicious distribution of his choices over trials. All members of the group gauge their behavior so as to maximize unanimity when unanimity is the criterion of the group choice. In the I-U and the I-MQ treatments there were 84 percent and 83 percent of trials with unanimous choices. The remaining trials are apparently left for individuals to recapture their own idiosyncratic preferences. Thus the person gives up very little by joining the group that works under unanimity or the minimal quorum: He attempts to maintain his previous choice preference and he only abandons the freedom of selecting the trials on which he votes for A or B. Of course, in groups operating under majority rule he needn't abandon either his idiosyncratic choice preferences or the sequential pattern of these choices over trials. One should not mistake these pressures toward unanimity for conformity. It is quite clear the individual does not give up the independence of his choices—only the timing of these choices. However, other studies do indicate some tendencies toward uniformity or conformity, as there usually is a restriction of variance when individuals move from the solitary to the group condition.

Because the majority rule affords the person not only the freedom to retain his idiosyncratic choice preferences, but also the freedom to select the occasions on which he will exercise one preference or another, it would seem that a group free to determine its own decisions scheme would lock in on the majority process.

Because a different decision task than that conventionally used in risky shift studies was examined in this experiment, one should be cautious in attempting to generalize to group processes occuring when individuals work with choice dilemmas. Nonetheless, on the basis of these results there is reason to doubt whether risky shifts (or conservative shifts) obtained with conventional materials, can be explained entirely in terms of changes in individual risk preferences with rules whereby these individual preferences are combined into a joint choice totally ignored.

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An Alternative for Structuring Scientific Congresses—First Results of Congress-Dynamics Investigations

Günter Ammon, with Gisela Ammon, Gislinde Bass, Jürgen Götte, and Peter Moldenhauer

Present-day scientific congresses are an anachronism. Since travel and information dissemination are easy, it is not clear why several thousand scientists assemble for conventions. Personal interaction is not possible when information is written. Actually, it is often just as impossible at congresses where communication becomes a series of sterile scientific presentations in which time limitations and prepared speeches inhibit spontaneous personal interaction. What really seems to be important is the beauty of the location, "extracurricular" activities, and the ladies' programs.

There are three principal types of congress programs: "representational" congresses whose aims are self-aggrandizement and propaganda for the sponsoring organization; congresses whose principal aim is instruction in the form of a unilateral communication from scientists to audience; and congresses whose aims are to generate research and theories by means of active communication among all participants.

"Representational" Congresses

Participants expect their sojourn to be as pleasant as possible with no onerous tasks inherent in participation. The individual's principal function is registration. Management is expected to have everything planned.

The "representational" Congress is marked by passivity. Unknown to one another, the members sit facing the rostrum and what is relevant takes place on this rostrum; everything else—the satisfactions and frustrations of the participants—is ignored. Owing to the lack of "give and take" among participants, any prospects for change in the congress' structure or program are thwarted.

Often the Representation Congresses are supported by the scientific establishment, the hotel and tourist trade, or certain industries—all irrationally demanding supremacy on the part of the scientific lords. Depersonalized seating arrangements treat the speaker and his audience as opponents, and preclude effective interaction between the two.

The Casa-Congress: Group Needs Determine the Course of the Congress

The idea for international symposia in analytic group therapy grew out of dissatisfaction with traditional large congresses. The structure of the Casa-Congress developed from spontaneous needs and must not be regarded as apart from the context under which it took form: the location at Paestum, Italy; the 1969 International Congress of Psychoanalysts in Rome; and the instructors and students at the Teaching and Research Institute for Dynamic Psychiatry and Group Dynamics.

The course of the 1969 International Congress of Psychoanalysts in Rome, a type of "representational" Congress, led to the formation of a counter-congress by younger analysts of the International Association of Psychoanalysts (IAP). The IAP attempted to ensure the smoother running of the 1971 congress in Vienna by setting up a pre-congress for novices who met together in order to avoid dominance by the gerontocracy.

However, the IAP, as any other petrified institution, considered free, unregimented discussion a threat to its existence, and retained unaltered the structure of the main congress.

The Casa-Congress may be described as follows: All scientific papers presented result from a group effort that serves an emancipatory concept. Actual accomplishments and stated aims are not separate, but are monitored and coordinated by a team of scientists representing each group. The Casa-Congress has a limited number of participants—for example, the third and largest symposium in 1971 was limited to 140 persons. The Casa-Congress serves to represent a working research group, not a dogmatic group. It takes into account the concept which regards small conferences as prerequisities for working out new problems. Insofar as possible, the congress structure forms a "facilitating environment" in order to encourage creative cooperation.

Research on Congress Dynamics

The instruments for congressional research are: observation by participants, a mammoth session in group dynamics, questionnaires, evaluation of films and photographs, informal interviews, tape recordings, and joint evaluation by the participants at the end of the congress.

The report considered here concerns mainly the Second Symposium in Paestum, 1970, where Casa-Congress participants managed the proceedings themselves. The First Symposium in 1969 had included a large number of presentations—17 speeches in 4 days—along with three social events, three tours, and one panel discussion; at the end a congressional research group was formed. The Second Symposium, in contrast, contained only nine speeches in 5 days, six working groups, three groups for investigating the congress dynamics, two tours, and one social event.

Sociometric studies of the congress showed a triangular dynamic consisting of the managers (Group A), the critics (Group B), and the participants (Group C). Differentiation of the three subgroups is supported not only by questionnaire results, but also by the results of direct observation of a team of participant-observers. Group A participated mainly because of their managerial responsibilities and wanted to exchange information with scientists in order to foster the aims of their organization; they showed particular concern for a group of instructors and students who had little experience with congresses and who were unprepared for effective participation. Group C had less interest in the scientific material as a motivating reason for attending the Symposium, but revealed an emotional "transference" relation with the Symposium director coupled with a sense of loyalty, admiration, and even with opportunistic tendencies. Group B (Critics) had learned about the symposium from professional journals or had come to represent institutions where they worked; they wanted information about groups and aggression, and they expressed interest in training for group psychotherapists.

Groups A and B were work-oriented. Group C expressed the wish for a vacation, and expected Group A to submit to it a complete and accurate report on the congress. Group B expected a professionally qualified but more reserved group.

Subjective Evaluation of the Symposium

Group A exercised self-criticism. Members were happy with the

speeches, found the social contacts to be stimulating, but never felt intense involvement. They typically found the group dynamics among congressional participants to be the most surprising and unexpected aspect of the symposium.

Group B agreed with the scientific program and rated social contacts from "satisfactory" to "good." They received some stimulus for their own work, and they evaluated the managers as "satisfactory." Group B found the surprising and unexpected aspect of the meetings to be the management group, and the very small number of delegates.

Group C members felt satisfied with the scientific program, the stimulation for their own work, the social contacts and surprisingly listed the structure of the congress, the congress dynamics, and the management also.

Group B wanted to build more group psychotherapy into their training and work program, while Group A was interested in research on aggression. Almost all delegates felt that scientific problems were adequately discussed.

The group-dynamics sessions became the most important instrument of the research project. They had been planned as part of the program from the beginning, and every delegate knew that the congress would also serve as an experimental research vehicle. The number of participants for the mammoth groups was not limited; anyone could take part and could join or leave at will. Almost all participants were intensely involved in the proceedings, and sessions lasted longer than the 2 hours planned for them. With regularity smaller groups would form for meetings after the main sessions. The strength and the value of the symposium were revealed by the extent to which management could tolerate exceptional tension—tension so severe that group sessions planned for several hours had to be extended. In one case the delegates remained until dawn, discussing the events of the group session. This group on self-study, a unique experience for the group psychotherapist, showed that hidden psychic processes are in the background of scientific gatherings, but in traditional congresses they do not serve an educative function, or they are submerged in rationalizations.

Questionnaire results showed that the delegates deemed the mammoth group to be the most meaningful experience, and an excellent adjunct to the scientific program. The mammoth group reflected the entire congress and provided an opportunity for scrutiny, so that the latent psychological dimension of the group became manifest.

Conclusions

Congress successes hinge on preparatory and evaluative activities which culminate in the session. Since it is imperative to exploit constructively the buildup of tension through the delegates' participation in preparatory tasks, it has been suggested that work groups should begin to form subgroups before a congress starts. The principal aim of such groups is the establishment of the congressional group. Therefore, several people from one city should formulate subgroup expectations, so that intragroup differences in expectations can be reconciled and satisfied. The result of such planning then becomes a lively interchange—by mail or discussion—which shows less the characteristics of official communication than of meaningful working relationships. In this way participants can begin to feel their roles even before the sessions

begin, and individuals need not struggle to enter the groups.

Individuals or groups who are known to differ markedly from the opinions of management, but whose participation is desirable, should be included in preparations from the very outset. Eventually it will become necessary to enter into discussions with them anyway. The position of the congress must be clear. Is its aim constructive disagreement or the avoidance of conflict?

It is imperative to plan and structure the congress with a specific aim. It is necessary to assign priorities for principal and secondary goals to avoid conflicts of interest. Possible goals could include: common agreement on professional-political strategies, presentation of theories and their application in teaching and learning models, subgroup confrontations for teaching and experimentation (self-study groups), intensive interchange of personal practical experience, collective effort in a concrete project, and self-representation of a working group.

Intercultural differences must be taken into account at international congresses. At the Paestum Congress of 1970 it became obvious that refusal to adapt to another's style also means refusal of the subject matter communicated.

The generation problem may harden into a typical family dynamics problem, particularly in the relation between the delegates and the leaders. The congressional hierarchy is fraught with anxieties, especially with the fear that management could lose control of an open debate and, in so doing, cause the disintegration of the session. It must therefore be remembered that any sort of opposition to the management of the congress can be fortified when it is composed of people who appear weak and sense their own incompetence, or when the management has somehow communicated that it is weak, and that an attack against it would be tantamount to the collapse of the meeting. The Casa style and the congress-dynamics groups can help prevent these consciously and unconsciously camouflaged tactics.

All delegates, guests, observers, hangers-on, and press representatives should be informed that the session itself is the substance and the foundation for congressional research. Any participant, therefore, will realize his responsibility; he will know that his behavior will be carefully observed and that certain conclusions will be drawn from it; in this way even the silent ones' concern or nonconcern becomes the substance of scientific interest. Thus, congressional research means joint interaction with joint learning processes.

Casa-style innovations through the study of sociodynamic and depth-psychological aspects of scientific congresses give us guidelines for establishing optimal scientific cooperation, and for developing the creativity of the group.

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The Image of Man Implicit in Encounter Group Theory

Sigmund Koch

Scientific psychology was stipulated into life in the late 19th century. That optimistic age decided to try out a new strategy: extending the methods of natural science to human and social problems. At the beginning, there was some degree of realism about the magnitude and difficulties. But the *image* had been created, and in almost no time the ever-autistic character of man under challenge asserted itself. The hope of psychological science became indistinguishable from the fact of psychological science. The subsequent history of psychology can be seen as a ritualistic endeavor to emulate the forms of science in order to sustain the delusion that it already *is* a science.

As a result, the inability of anyone to fix the limits of the metaphor known as "psychological science" has been close to catastrophic. Strange things happen when image is seen as fact! Numbers are assigned to millions of people in the line of intelligence, personnel, or educational "measurement" with little regard for their meaning and none for their effects on the dignity, self-image, or fate of the victims. Guesses about the importance of permissiveness, fondling, breastfeeding, social reinforcement, and the potentialities of teaching machines or computerized instruction influence whole eras of parental and educational practice. "Breakthroughs" are applied to the "cure" of the mentally disturbed: little interventions like partial destruction of the frontal lobes, or malarial, insulin, or electroshock. For the less refractory disorders, or for soul-expanding kicks, psychological "science" has its armamentarium of "psychotherapies," most of them devised with minimal concern for whether the presumably neurosis-free or expanded person who emerges has not also been freed of large areas of his personhood.

But what is worse than any single symptom of psychological science is something more like an essence: it is the demeaning image of man himself at the basis of its presumably tough-minded conceptualization, an image which mankind cannot but accept and strive to emulate because of its association with the iconology of science. It depicts man as a stimulus-response mechanism or, worse, a mathematical point of intersection between stimulus and response processes, and steered by socially "manipulated" rewards and punishments. According to this form of the image, the laws of human and social "behavior" can be derived from study of the variables controlling the rate at which a hungry rat presses a lever to obtain pellets of food. The more sophisticated and recent form of the image holds man to be an information-processing entity operating on the principles of a binary digital computer programed to conform to payoff criteria acting much like the rewards of the previous case.

Both of these "images of man" are products of the tradition of behaviorism, which for 50 years has maintained hegemony, especially in this country. The behavorisms are an assertion of man's reality-defining propensities in that they achieve the liquidation of psychology's subject matter: the elimination of experience and mind. My purpose here is best served by resting the case with these few contumelious remarks, which I

hope will suffice as a background to my story.

By the mid-fifties, many psychologists had become restive over the behaviorisms and were searching for more significant professional and human commitments. At about this time, Maslow, who had complained about the "means-centeredness" and scientism of psychology and who was discovering existentialism called for a "third force" in psychology. Fairly soon, a group—calling themselves "humanistic psychologists"—emerged.

By a process which no one has chronicled, the interests of this group began to concentrate on group therapy. The pre-"humanist" tradition in group therapy took its conceptual inspiration primarily from psychoanalysis and the "depth" psychologies. By the mid-fifties, however, a number of group approaches to therapy, based on principles of "group dynamics" and other non-depth psychological schemes, were in the air. Drawing their ideas from these and other scattered sources, the humanistic psychologists began to experiment with an ever-widening range of eclectic mixes.

Today the group movement has become the most visible manifestation of psychology on the American scene. It has captured the interest of a majority of students and investigators who wish to maintain contact with a human subject matter. It is important that we assess its message, impact, meaning, "image of man."

I will give my assessment by saying that the group movement is the most extreme excursion of man's talent for reducing, distorting, evading, and vulgarizing his own reality. It is also the most poignant exercise of that talent, for it seeks and promises to do the reverse. It is adept at the image-making maneuver of evading human reality in the process of seeking to discover and enhance it. It seeks to court spontaneity and authenticity by artifice; to combat instrumentalism instrumentally; to provide access to experience by reducing it to a packaged commodity; to engineer autonomy by group pressure; to liberate individuality by group shaping. Within the lexicon of its concepts and methods, openness becomes transparency; love, caring, and sharing become a barter of "reinforcements" or perhaps mutual ego-titillation; esthetic receptivity or immediacy becomes "sensory awareness." It provides a psychic whorehouse for the purchase of a gamut of existential "goodies": Authenticity, freedom, wholeness, flexibility, community, love, joy. One enters for such liberating consummations but settles for psychic strip-tease.

Those are strong words, and it will not be easy to make them plausible to those who feel differently. There is no question of proof in relation to such matters. It is a question of seeing, of fidelity of perception of the human condition—and this kind of question is as old as the history of man and will never be resolved. But the history of the humanities has given us many differentiated, sensitive, ardent visions of the human condition. All of us are capable of sharing in, and even extending, this noncounterfeit kind of vision—but that comes the hard way, the way that involves fear, trembling, loneliness, discipline, gallantry, humor, and a loving if ironic sense of the dimension of human imperfectibility.

The autisms of those who want it the easy way have put them out of touch with the differentiated content of the significant visions in man's heritage; worse, they are out of contact with the intricate and delicately contoured meanings of some of the best—

and plainest—words in our language. They use these words with the best of intentions but in debased, vulgarized, schematic ways. Words like openness, honesty, awareness, freedom, trust, growth, feeling, experience form a simplistic conceptual abacus which they manipulate and apply in mechanical, repetitive, incantatory fashion.

What concerns me about the group movement is the image of man it has purveyed to man. The central horror of the history of psychology is that distorted images of human reality are soon accommodated by the reality which the images distort. Perhaps more frightening is the reported yield of "successes." The principal toll of the movement is in the reducing and simplifying impact upon the personalities and sensibilities of those who emerge from the group experience with an enthusiastic commitment to its values.

Concentration upon *self-disclosure* is the hub, nub, pivot, and growth-releasing agency of the group process. Growth toward freedom, autonomy, authenticity, spontaneity, expressiveness, flexibility, or realization is released by self-disclosure in a group situation in which all the atmospheric variables militate toward mutual self-definition and the "direct" expression of response (whether hostile, loving, or other) by all members to any given member in process of disclosing. When theoretical analysis is attempted, it is customary to point to the joint interplay of reinforcement and feedback in shaping each individual's movement through the group experience. Such variables may be supplemented, in some accounts, by postulating natural healing tendencies which are liberated in individuals by the group process. That is about the size of the rationale.

Some profound questions may be raised. Are all so-called "facades" phony and psychically crippling accretions? Are all surface-traits facades? If there is a distinction between a surface-trait and a facade, who is to make it? Is every individual or reference group competent to do so relative to a given case? Who is qualified to tell Proust to get rid of his fur coat and his hypochondria; Eliot to ditch his reserve; Mann his rather bourgeois surface rigidities; Gide his exhibitionistically asserted homosexuality; Joyce his propensity for occasional fugues of high living; Dylan Thomas his alcoholism and arrogant scrounging?

But there are deeper problems here. The concept of *transparency* serves to mask certain of the most pervasive and potent conditions constitutive of value. Total transparency is constitutive only of nullity, and human beings in process of approximating or sustaining transparency are among the most boring phenomena in creation. We all have run into those bores who want to apprise you of the content of their souls, not to mention the consistency of their feces and their taste in deodorants. We usually feel guilty over such boredom, for we know that they are sick. But the point I am trying to get at is more subtle and important than such illustrations convey.

We often talk about prizing "depth" rather than "transparency" in people and their artifacts, and elsewhere. But "depth" is a rather coarse-grained and unilluminating concept, as generally used. Reflection will show that what we prize in our perception of people, or of art, or the natural world, is a special, difficult-to-specify relationship between surface-qualities and interior or depth-qualities. Whatever the ultimate

analysis of such matters, we are so constituted perceptually and affectively as to derive intense and differentiated value from carriers of such relationships. To take a simple perceptual example, most of us differentially value a color which somehow mysteriously emerges from the depths of an exquisite gem as against a color of similar spectral properties in the form of a pigmented surface patch. In every form of art what we maximally respond to—when we respond competently—is a set of special and complex relationships between surface and interior properties.

Until recently, most of us recognized such qualities of human beings as the charm of certain forms of reticence; the grace of certain kinds of containedness (which need not mean rigidity but which can be definitive of dignity); the communicative richness of certain forms of understatement, allusiveness, implicativeness; the quality of that kind of modesty which is the outward form of the capacity to prize personhood and to love directionally rather than diffusely. Some of us even used to be charmed by the kind of "openness" which is not transparency nor hearty and robust explicitness but, rather, a capacity to focus sensitively, precisely, and even vulnerably upon value-laden human and natural objects, and an analogous gift for allowing the self to emerge into focus, without surrender of dignity or modesty, for valued others.

The encounter groupers say "that is precisely what we mean" when I attempt such specifications of the ineffable. They will never convince me—for everything they *do* can only obfuscate, belie, and destroy such distinctions.

I am not maintaining that the encounter movement does not grant ontological legitimacy to the individual or that it espouses some form of a Group Mind position. I *am* trying to convey that the pursuit of "openness" via self-revelation before an adventitiously assembled group of strangers centers the process of individual self-definition heavily upon group response. What is implicit here is a simplistic and crass "solution" to the immensely complex and delicate question of the relation of man and society, one which assigns as much weight to the social shaping of the individual as do the most rigid theories of a social determinism. I suspect that lurking under all this is a deep misconstrual of the concept of democracy. This is the sense of the democratic process as an egalitarian merging of happy, well-met, mutually voyeuring "people," rather than a system of agreements guaranteeing maximal dispersion of social control and minimal invasion upon both self-determination and privacy.

The differential assessment of the force and value of real-life experience as against encounter group experience is frequent in the group literature. Up to a point it is correct, but this constitutes one of the grave threats of the group movement. What is said about the force and immediacy of group feedback cannot be denied. But it is dangerous for an adventitiously selected group to have this degree of force in controlling the individual's self-image. The assumption seems to be that any old kind of feedback is fine—regardless of the degree of sensitivity, general quality of sensibility, etc. of the feeders. The chances for simpleminded, callow, insufficiently considered, or reductive shaping of the individual are high.

The defense against this argument is: Are the chances any better in actual life? This is superficial. The

chances of winning sensitive "feedback" are probably meager. But in "ordinary" life we are recipients of multiple and disparate feedbacks; we are protected by this dishomogeneity from the sense that our essence has been caught and fixed by our assessors. Besides, any assessment is less likely to be perceived as peremptory; we tend to assess our assessors. We do not "enter" ordinary life, as we do an encounter group, with expectations of self-clarification or improvement; usually we are merely *there*. In life we may pay for our follies, but we do not commit the folly of buying feedback from our friends. Indeed the dynamics of friendship are such that people receive much of their feedback from individuals of comparable or higher sensitivity, rather than lower.

However inefficient the ordinary conditions of character formation, it is diabolical to make these contingent on group engineering. Moreover, it is the very "effectiveness" of the group situation which is its great danger. The ambiguities and delays in feedback in normal, nonengineered life are safeguards—guardians of the significant form of authenticity which can only be achieved by allowing intrapersonal factors the fullest possible play in development. The capacity for individual transcendence of the group is perhaps the most value-charged gift of the human station.

I have made reference to the gross and debased ways in which encounter groupers use certain humanly precious words. The deficiency is no mere matter of literary or conversational inelegance. If an image of personhood be specified in coarsened terms, then that image is a coarsened one in comparison to the image that might be specified via more sensitive use of the self-same terms. When this degraded image becomes criterial with respect to the desirable directions of personality change, we can anticipate only a degrading of personhood in the course of efforts to move the person toward such "ideal" qualities.

The mechanical way in which the groupers use concepts like authenticity, love, autonomy, and the rest in the rhetoric that passes for theory, but which controls the selection of their methods and practice, reveals and promotes a serious impoverishment of sensibility.

I will conclude with one example of such crippled and crippling uses of language. In encounter group parlance, "trust" is that homogeneous enzyme secreted by a group which catalyzes the process of self-exposure by decreasing the apparent risk-contingencies. The person will "let himself be known" because his share of the collective ambience of trust gives him a sense of safety.

"Trust" is no simple notion; it is not an undifferentiated, global matter. I can trust someone's good intentions, or his friendliness, or that he will not steal from me, or that he will not covet his neighbor's wife, or covet mine, yet distrust his capacity to perceive me, or him, or them, or it with clarity, delicacy, or precision. Or I can trust X's ability to see me with nicety and in depth, but not his ability or disposition to respond in a way congruent with his perception, or to use his perception of my trust in any way that may be congenial, constructive, or safety-engendering from my point of view.

More revealing than the groupers' general theory of trust is their understanding of it as signalized by one of their "nonverbal communication methods." "Trust" is presumably instilled by asking members of a group to fall backwards on the assumption

that another member stationed behind the faller will catch him. Now, this may serve as a screening device for detecting whether the presumptive catcher is a psychopath, but has nothing to do with trust. Any designated catcher who played the practical joke of allowing the faller to crack his head on the floor could justly be thought the owner of a character defect. A catcher, however, who did carry out the function of catching could only be thought to be a man capable of playing a game according to prescribed and easily applicable rules. But the faller would have no warrant for regarding the receiver trustworthy as a recipient of psychic confidences.

The encounter group carries every earmark of a shallow fad. Yet the impetus behind it is poignant and powerful, and embedded in man's condition. However compelling its impetus, this fad will fizzle out. But its *effects* need not.

When value-charged discriminations drop out of man's ken, there is no certainty that they will be rediscovered. We transmit to the future what we are. We may be what we eat, but we are also what we image. If what we are has been reduced by shallow or demeaning images, that impoverishment will persist long after the images that conveyed it have gone their way.

Postscript

I have presented this paper to several groups—including many leaders of the encounter movement, and have been treated with great lenience. In general, the pattern of response has been: that I have rendered the movement a service by raising a set of genuine problems; that some of these problems point to deficiencies in inexpert, crass, or meretricious group leaders, but *not* in expert, sensitive, and saintly ones; and that most of my demurs hold only for a subset of "approaches" within the domain of the "encounter movement."

I hope they are right! I respect the motives, the quality of intent, behind the encounter movement. And I deplore the circumstances—whether these be phrased as "alienation," "dehumanization," "depersonalization," "emotional anesthesia," "anonymity," "existential nausea," or simple loneliness—which have triggered the movement. But I suspect that the votaries of encounter have to be wrong in their belief that my demurs are applicable only to some but not all of the "approaches," or that my reservations point to remediable deficiencies. For the essence of my position is that there are generic characters common to all "encounter" approaches which render the group process self-defeating relative to meaningful fulfillment of the stated objectives.

Note: The editor of the *Journal of Humanistic Psychology* has asked the *Digest* to state that the *Journal* publishes many viewpoints on vital issues in humanistic psychology, even critical viewpoints such as those of Dr. Koch, and that interested readers might wish to consult the Fall 1971 issue of the *Journal* for opposing arguments to Dr. Koch's article.

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Toward a Triadic Theory of Meaning

Walker Percy

If most psychiatrists were asked why they don't pay much attention to the linguistic behavior of their patients, they might give two sorts of answers: I have to be more interested in what the patient is saying than in the words and syntax with which he says it. Or, we know that conversation is a series of learned responses, but these are subtle events, occurring mostly inside the head, and so there is not much we can say about them in the present state of knowledge.

What follows does not pretend to offer the psychiatrist an adequate theory of language. It is adapted freely from the work of Charles Peirce, the American philosopher. Hopefully it might either sufficiently stimulate or sufficiently irritate behavioral scientists toward the end that they will devise operational means of confirming or disconfirming these statements—or perhaps even launch more fruitful studies than this tentative investigation.

Peirce believed that there are two kinds of natural phenomena. First there are those events which involve "dyadic relations," such as obtained in the "physical forces . . . between pairs of particles." The other kind of event entails "triadic relations": "All dynamical action, or action of brute force, physical or psychical, either takes place between two subjects . . . or at any rate is a resultant of such action between pairs. But by 'semiosis' I mean, on the contrary, an action, or influence, which is, or involves, a cooperation of three subjects, such as a sign, its object, and its interpretant, this trirelative influence not being in any way resolvable into actions between pairs."

If A throws B away and B hits C in the eye, this event may be understood in terms of two dyadic relations, one between A and B, the other between B and C. But if A gives B to C, a genuine triadic relation exists. An index sign is part of a dyadic relation. An index refers to the object it denotes by virtue of really being affected by that object (e.g., a low barometer as an index of rain). A symbol, however, is something which stands to somebody for something in some respect or capacity.

Dyadic events are, presumably, those energy exchanges conventionally studied by the natural sciences: subatomic particles colliding, chemical reactions, etc. Triadic events characteristically involve symbols and symbol-users. A genuine triadic relation cannot be reduced to a series of dyadic relations. Peirce seems to be saying that when a symbol-user receives a symbol as "meaning" such and such an object, we may *not* understand this event as a sequence of dyadic events or energy exchanges even though dyadic events and energy exchanges are involved.

Peirce's distinction between dyadic and triadic behavior has been noted before, but so pervasive has been the influence of what might be called dyadic behaviorism that Peirce's "triadic relation" has been recognized only to the degree that it can be set forth as a congeries of dyads.

If triadic activity is overt behavior and as such is the proper object of investigation of a factual behavioral science, and is not formulable by the postulates and laws of conventional behaviorism, what manner of postulates and laws, if any, would be suit-

able for such a science?

The following is a loose set of postulates and definitions which I believe suitable for a behavioral schema of symbol-use and which might be adapted from Peirce's theory of triads. There are two main departures from Peirce's theory: No account whatever is given of Peirce's ontology of Firstness, Secondness, and Thirdness in terms of which his semiotic is expressed; what is offered is not a comprehensive theory of signs but only a tentative account of sentence utterance, that is, sentences considered as items of behavior. The emphasis is clinical, that is, upon *mistakes,* misperceptions of sentences in their transmission from sender to receiver. There are two reasons for this emphasis: The clinical encounter of therapist and patient is the recurring paradigm in the article, and that mistakes suggest a useful method of exploring this treacherous terrain.

(1) The basic unit of language behavior is the sentence. A word has no meaning except as part of a sentence. Single-word utterances are either understood as sentences or else they are not understood at all.

(1.1) A sentence-utterance is a coupling of elements by a coupler. The subject-predicate division is not the only kind of coupling which occurs in sentences. Not only can symbols be coupled with symbols; symbols can also be coupled with things or classes of things. Peirce's example: A father catches his child's eye, points to an object, and says "balloon."

(1.2) A sentence-utterance is a triadic event involving a coupler and the two elements of the uttered sentence.

(1.21) If a dyadic relation is abstracted from a triadic relation and studied as such, the study may have validity as a science, but the science will not be a science of triadic behavior.

A professor writes a sentence on the blackboard: *The King of France is bald.* The class reads the sentence. If one considers this sentence-utterance as an item of behavior, one quickly perceives that it is a pseudo-sentence. The phrase *the king of France* does not refer to anything since there does not presently exist a king of France. Also, a second condition of bona fide sentence-utterance is lacking. Asserting a sentence is something like going before a notary and taking responsibility for it. No one imagines the professor has done this.

(1.3) A name is a class of sounds coupled with a thing or class of things.

(1.31) It is the peculiar property of a name, a class of sounds, not only that it can be coupled with a class of things but also that in the coupling the sound is transformed and "becomes" the thing.

(1.311) A symbol must be unlike what it symbolizes in order that it may be transformed and "become" what is symbolized. The sound *cup* can become a symbol for cup. A cup cannot be a symbol for cup.

(1.4) The coupling relation of a sentence is not like any other world-relation. Yet it may symbolize any world-relation whatever, subject only to the context of utterance and the rules of sentence formation.

(1.41) A sentence may mean anything it is used to mean. The sentence *baby chair* uttered by a 2-year-old can be understood by its mother as asserting within different contexts any number of different relationships.

(1.42) The coupling relation of a sentence is not isomorphic with the world-relation it symbolizes. It is true

that the sentence *John loves Mary* is a coupling of sentence elements referring to a dyadic relationship between John and Mary. But it is also true that although the sentence *John gives a ring to Mary* refers to a triadic relation obtaining between John, the ring, and Mary, the sentence is still a coupling of elements: (1) We are speaking about John, (2) we are saying something about him.

(1.5) When one studies dyadic behavior, i.e., the learned response of an organism to stimuli, it is proper to isolate certain parameters and variables. These include: Amplitude of response, latency of response, frequency of stimulus, reinforcement, extinction, discrimination, and so on. But if one considers triadic behavior, i.e., the coupling of a sentence by a coupler, a different set of parameters and variables must be considered.

(1.51) Every sentence is uttered in a *community*. The community of discourse is a necessary and nontrivial parameter of triadic behavior. It is impossible to think of an exchange of sentences occurring otherwise than between two or more persons.

(1.511) In triadic behavior, the dimension of community can act as either parameter or variable. It is a parameter, for example, in an ongoing encounter between therapist and patient: The community does not change. It is a variable when the community varies. The meaning of a sentence can well be a dependent variable, depending on the independent variable, the changing community.

(1.52) An environment has gaps for an organism, but the world is global, that is, it is totally accounted for, one way or another, rightly or wrongly, by names and sentences.

(1.522) Sentences refer to different worlds. A sentence may refer to the here-and-now world, a past world, a future world, an imaginary world, a theoretical world.

(1.523) Since a sentence entails a world for both utterer and receiver, both utterer and receiver necessarily see themselves as being *placed* vis-à-vis the world.

Some sentences are uttered and received in the everyday world of market place and fireside. Other sentences, e.g., scientific propositions, are uttered, so to speak, out of the world, that is to say from a posture abstracted from the everyday world. From this posture world-items tend to or events to arrayed in causal chains. be seen as specimens to be classified The peculiar vocation of the therapist requires that he listen to both kinds of sentences, distinguish one from the other, and respond accordingly.

(1.53) Every sentence is uttered and received in a *meduim*. The medium is a nontrivial parameter or variable in every transaction in which sentences are used The medium is not necessarily the message, but the message can be strongly influenced by the medium.

In learned or instinctive behavior, a dog may respond to his master's whistle or to a recording of his master's whistle in the same way. But the sentence utterance *I need you* can provoke varying responses as the medium varies through which it is transmitted.

(1.54) Every sentence has a normative dimension. A sentence may be true or false, significant or nonsensical, trite or fresh, bad art or good art, etc. Sentences are items of behavior and these items have normative dimensions. Therefore a behavioral account of sentence-utterances must give an account of these norms.

True or false is only one normative dimension of sentences. *Clouds are*

fleece is false as a literal statement, true in a sense as a metaphor, bad in the sense of being a trite metaphor. Even nondeclarative sentences have normative dimensions. Patient says to therapist: "Don't you dare plot against me!" An imperative sentence and therefore neither true nor false but inappropriate because the therapist harbors no such plot. Patient to therapist: "I see what you mean." It is possible that the norm in question here is not whether the patient is telling the truth but whether he is uttering a sentence or a nonsentence, i.e., making a polite sound.

(2) The receiver of a sentence can take or mistake the sentence.

(2.1) A sentence may be mistaken by mistaking any one of the parameters of the sentence. A parameter of a sentence-utterance is a variable which is constant for a particular discourse but may vary from one discourse to another. Some of the parameters of sentence-utterances are: The mode of coupling of its elements, the community of discourse, the medium of communication, the world to which sentence refers, the placement of utterer and receiver of sentence vis-à-vis its world, and the normative mode.

(2.11) The receiver of a sentence can mistake it by miscoupling its elements, that is, by coupling the wrong elements or by coupling the right elements in the wrong mode or parameter.

(2.111) The receiver of a naming sentence can receive the name correctly ar.d look at the same object the namer looks at, yet nevertheless mistake the sentence by making the wrong worldslice (abstraction) of the class of objects named.

(2.112) There is an interface between scientist and layman such that a sentence uttered by the former is subject to characteristic miscouplings by the latter.

(2.1121) The lay-science interface often leads to a reversal of roles wherein the scientist-therapist "laicizes" his sentences, while the layman-patient "scientizes" his, with characteristic miscouplings attendant upon both.

(2.12) The receiver of a sentence can mistake it by mistaking the world to which it refers.

Thus it is not enough for the receiver to "know what the sentence means." One must also know whether it is a report, a story, an account of a dream, a joke, a quotation, etc.

(2.13) The receiver of a sentence can mistake it by the placement of the utterer vis-à-vis the world of the sentence.

Therapist (after a long silence): "What comes to mind?"

Patient: "I've decided to break off the analysis."

Therapist: "Tell me about it."

Instead of replying, the patient rises, shakes hands, and leaves.

The therapist mistakes the placement of the patient vis-à-vis the world of the sentence *I've decided to break off the analysis.* He, the analyst, assumes that the patient has uttered one more sentence in the language game of analysis, i.e., a game where sentences are reports of data to be examined rather than announcement of actions to be taken. Whereas in truth the patient has shifted the world of discourse from the L-game of analysis to the language of the everyday world where, when one announces his departure, one departs.

(2.14) A sentence can be mistaken in its normative mode, that is, by being received in a normative mode other than that in which it was uttered.

Therapist (after a long silence):

"What comes to mind?"

Patient (seeing the curtain at the window stir in the breeze): "There's a rat behind the arras."

Therapist: "Who's the rat?"

Patient: "Polonius."

Therapist: "Don't forget that Hamlet mistook Polonius for the king."

Patient: (agitated): "You mean—it's oedipal? Hm. No. Yes. It is!"

It is impossible to characterize the sentence *There's a rat behind the arras* by the conventional propositional norm of true-or-false. There is no rat behind the curtain. But neither patient nor analyst supposes that the sentence asserts anything about a rat. The sentence is rather an allusive ambiguous assertion with more than one referent. It is, let us stipulate: A playful allusion to the circumstance that both patient and analyst saw a performance of *Hamlet* the night before, a reference to a dream, a surfacing of unconscious oedipal feelings.

We want to observe this conversation, not through the analyst's eyes which see the patient as a psychic malfunction but through a zoom camera which zooms back in order to see the encounter as it occurs, between two sentence-couplers, in a world, in an office where a certain L-game is played, next to a street where other L-games are played. Thus, instead of seeing the patient through the analyst's eyes as a dyadic creature whose distress may be traced to "repression" and "resistance" to the disclosure of unconscious contents, we see a certain sort of educated lay person who is very much aware of the L-game being played here, very much aware of the analyst's theories, very much aware of the difference between being in the world of the analyst's office and being in the world of the street outside.

The agitation manifested by the patient in the last sentence of the conversation may have a different source than the dyadic distress ordinarily attributed to him. Conventionally the patient is supposed to resist the attribution to him of oedipal feelings. But is it not possible that in this case what was thought to be dyadic misery may turn out to be triadic delight? So that far from being like one of Freud's Victorian patients who "resisted" the disclosure of such unconscious contents, this patient may be a late Twentieth-Century man who likes nothing better than to exhibit the proper pathology. "It's oedipal!" exclaims the patient with every sign of delight.

Granted the shortcomings of the two major methodological approaches to the talking patient—the analytic-psychical and the organismic-behavioristic—is not the sole remaining alternative the novelistic (or phenomenological)? Freud and Skinner put forward dyadic models, one for organisms interacting in an environment, the other for invisible "forces" interacting within a psyche. To us now, Freud's and Skinner's models are demonstrably right and useful in their way, but how do you get from one to the other?

Charles Peirce proposed a radical theory of signs which undertook to give an account of those transactions in which symbols are used to name things and to assert sentences about things. In view of the heroic and generally unavailing attempts during the past 50 years to give such an account through one or another dyadic theory, it might be worthwhile for once to approach triadic behavior with a genuine triadic theory. Such a theory might bestow order and system upon the phenomenologizing which to the behavioral scientist must seem closer

to novel-writing than to a science of behavior.

For example, the oedipal patient's agitation may be given such preliminary reading as follows: The patient's agitation is not dyadic misery—resistance to the disclosure of unacceptable unconscious contents—but triadic delight. It is a naming delight which derives from the patient's discovery that his own behavior, which until now he had taken to be the unformulable, literally unspeakable, vagary of one's self, has turned out not merely to be formulable, but to be namable with a name which is above all names: *Oedipal!*

As such, the patient's delight has good and bad, authentic and inauthentic components which must be traced out and identified within an adequate triadic theory. Thus, the patient's sentence *It's oedipal!* must be investigated for Platonic and even magical components in its mode of coupling, as well as, for its valid intersubjective celebration of an important discovery.

Accordingly, the patient's behavior with its strong normative components must be evaluated on a normative scale which is in turn an integral part of the triadic theory in question. It is impossible in other words to avoid the subject of the patient's impoverishment and loss of sovereignty.

In his astounding achievement of applying the scientific method to the irrational contents of the unconscious, Freud did not have time to consider what goes on between doctor and patient, nor how a technique itself can loom large as part of the intellectual furniture of a later age, much less how it could come to pass that one can fall prey to the technique one seeks help from. But that does not excuse us from investigating these matters.

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Reprints of original article from Walker Percy, M.D., Box 510, Covington, La. 70433.

The Multi-State Information System for Psychiatric Patients

Eugene Laska, George W. Logemann, and Abbott Weinstein

The Multi-State Information System for psychiatric patients (MSIS) is a project developing an automated information and management support system in the field of mental health. At present, Connecticut, Hawaii, Massachusetts, New York, Rhode Island, Vermont, and the District of Columbia are cooperating in this effort; however, the system is open to new participants as well.

The basic objectives of the Multi-State Information System project are to develop an automated patient data system for clinical recordkeeping for use in mental hospitals and community mental health facilities and a management support system for facility, area, and State administrators; to provide clinical data as well as management data and comparative multi-State summary statistics useful for the evaluation and planning of programs and treatment procedures and for the administration of mental health facilities; to carry out research in statistical methodology in order to provide techniques and procedures for the evaluation and the interpretation of data collected by the systems developed and used in this project; to do basic research in computer science and methodology in order to provide better tools with which to implement the data system and evaluate the success of the program; to carry out specific programs of study and application of the data obtained in this project to problems in epidemiology, mental health planning, utilization review, program evaluation and operations; to provide a current up-to-date base of information on psychiatric patients for use by researchers; to make available to project participants and others the programs and the results of the research efforts of project participants.

The MSIS has been designed to follow the patient through all phases of psychiatric service systematically recording key elements of his treatment. As elements of each patient's record enter the file, reports reflecting the information submitted are prepared by the computer and returned to the source. The major effort in developing the MSIS has been carried on at the Information Sciences Division (ISD) of the Research Center at Rockland State Hospital and at the New York State Department of Mental Hygiene (DMH), where a staff including programers, systems analysts, computer scientists, psychiatrists and other mental health professionals, and statisticians are creating the forms and data-processing systems needed to gather patient information and are assisting in the analysis of the information gathered.

Information Flow

Information about patients is gathered on preprinted questionnaires developed by participants in the MSIS from which data are either read by machine or keypunched. Once data have been recorded as part of the clinical process, they are sent by mail or transmitted over telephone lines from terminals located in facilities in each cooperating State to the central computers. To meet the requirements of MSIS, ISD maintains two central processing units; the use of the dual configuration at ISD is based on the need for backup.

Every form submitted to MSIS is automatically checked for errors by the computer, insofar as possible.

Whenever a transaction is partially accepted or rejected, an error message is printed out, suggesting ways in which the error may be rectified by personnel at each facility. Clinical, administrative, and research reports are then transmitted from the computer center and printed at the appropriate terminal.

Project Organization

Each participating State delegates a liaison representative, generally directors of statistics and information processing within their respective States, who becomes a member of the Liaison Committee. In addition, each State sends representatives from the medical disciplines who participate in the forms-development aspect of the project as members of the Ad Hoc Committee on Forms.

Formulation of content—The design of the initial instruments of data collection for the MSIS required a review of previous admission, termination, and other existing medical recordkeeping documents and the aid of the mental health research and clinical communities.

The formal mechanism for arriving at consensus in the MSIS is through two committees: major developmental efforts have been carried on by the Liaison Committee for input documents to the census-keeping portion of the system, notably the Admission and Termination Forms for community services and hospitals and the forms recording patient movement and status changes. The Ad Hoc Committee on Forms, a group of clinicians noted for research as well as for leadership in their institutions, has major responsibility for developing and reviewing clinically oriented documents.

Application subsystems—Specific parts of the MSIS programs and procedures may be conceptualized as independent subsystems. These were developed with the use of conventions designed to integrate all applications. Also, programs were designed in such a way that new subsystems can be added without disturbing the existing ones. Each facility may elect to use only those portions of the system which are suitable to its needs.

Census subsystem—The census subsystem has been designed to keep exact records of the location and status of each patient. An admission procedure, dependent on correct use of the Admission Form, documents background information current as of the time of a new admission or a readmission. The Admission Form establishes the identity of the patient and records the initial ward/unit assignment, demographic data, an appraisal of presenting problems, information about previous psychiatric service, and source of referral. The movement/status procedure keeps track of patients' location and care status and includes the use of several alternative input forms. Output reports include admission notes, daily movement reports, alphabetic listings, patient movement histories, statistical profiles for a facility, and termination notes.

Patient progress subsystem—The patient progress subsystem was designed to record clinical appraisals of the patient's psychiatric condition. The data collection instruments that comprise the subsystem include a mental status examination, a psychiatric anamnesis, a series of progress reports, and a method of recording diagnosis. Reports derived from these forms are generally narratives reflecting the input data. Using as input data from the Mental Status Examination Report and the Psychiatric Anamnesic Record, a computer program (Diagno III) outputs one or more of 79 psychiatric diagnoses that are probable for the case.

MSIS drug subsystem—The MSIS drug subsystem designed to establish files of patient drug regimens is being field-tested in several locations. The major components to this subsystem are: a *drug order* form that contributes information to the central computer file and at the same time leaves a complete record of the signed drug order in the patient's folder in his ward: a *drug cancellation* procedure utilizing a carbon copy of the drug order; an *Information Processing System* allowing for general file maintenance (such as rectifying errors in the files); a *Drug Continuation System* allowing physicians to continue therapy at a constant level over a period longer than 30 days.

MSIS Statistical Report Generator Subsystem—To facilitate data analysis, the MSIS Statistical Report Generator Subsystem was designed so that useful multivariate statistics could be quickly and easily obtained in the form of crosstabulations. The user may generate reports in formats and using variables that he specifies at the time of his request.

Generalized Alphabetic Lister Subsystem (GALS)—GALS allows the listing of patients who satisfy specific criteria, these criteria being selected by the user.

Cathode ray tube applications—A series of application programs have been written to experiment with the use of Visual Display Terminal (VDT). These allow for generating on-line narratives and for interrogating individual patient records in the data base.

On-Line Research Computer Processing at ISD

The existence of the computer complex servicing the MSIS has enabled expansion of research activities both in terminal locations through remote job entry and at the Research Center at Rockland State Hospital. For over 2 years, ISD has operated a Data Control Unit to provide on-line processing for laboratories of the Research Center. This Data Control Unit is situated in the general vicinity of the research laboratories and is connected by some 400 feet of digital cable and channel repeaters to the computer. In addition, five portable terminal units were custom-built and located in laboratories of the Research Center for the purpose of communicating with the computer. Analog and digital cables were laid from the control unit to eight laboratories, to which the terminal units can be connected as required. This system allows the research scientist to transmit data to the computer as they are being produced during the actual course of an experiment, to have them processed in real time (if necessary), and to have resulting data transmitted back to the laboratory to drive displays or to control apparatus affecting the experiment itself.

In developing the MSIS, the ISD and the DMH have illustrated some of the contributions a computer complex can make in the field of mental health, and the information systems are meant to serve as models and prototypes for others whose information needs are similar.

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Reprints of original article from Eugene Laska, Ph.D., Research Center, Rockland State Hospital, Orangeburg, N.Y. 10962.

Meyer on Brain Research. An Interview with Dr. Patricia M. Meyer

Dr. Meyer is Research Associate in the Department of Psychology at The Ohio State University

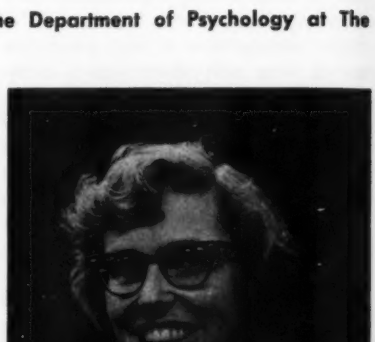
Q: Dr. Meyer, while we thought the main topic of our interview was going to be some discussion about women engaged in research—the particular problems of women and place of women in the profession as of today—we find that your work and career is in itself an outstanding example of the so-called liberated woman!

A: You may call it what you like, of course. But I, myself, have found no discrimination against, nor special favors for, women in the research lab. The important thing, I've found, is to go about your business like a pro, and try to do the best work you can.

Q: Nonetheless, there aren't very many women in neuropsychology or neurophysiology. Do you think that in growing up little girls are sort of expected to be a little squeamish about bugs and mice, and later shy away, too, from dissecting animals?

A: Possibly. In my own case, I was fascinated by zoology and coupled that with my interest in psychology to go into the neural branch of behavior. Being a girl, perhaps, kept me from any early hobby or interest in developing the technical skills I was going to need in the lab, such as carpentry or electronic experience. But in our kind of research one soon learns that you're on your own and you had better proceed boldly, and learn to design, build, and set up the equipment you need to run your experiments.

Q: What was the problem or question that led you into this whole field of brain research?



A: Both my husband and I were fascinated by what is really one of the oldest problems in psychology and neurophysiology—what mechanisms in the central nervous system contribute to learning and where are the sites of action?

Q: You have been working with your husband all along?

A: Yes. He was my faculty advisor for my doctoral dissertation at Ohio State University, where we still work. That was about 12 years ago. You may have read his Presidential Address presented at the meeting of the Midwestern Psychological Association in Detroit, May 1971. It was entitled *Access to Engrams* and describes some of our experiments.

Q: So you are still actively pursuing problems of the loci of learning and memory?

A: Yes, and while there are many questions still to be answered, our

results with our animal studies have given us several important clues, and have also raised possible implications for approaches to victims of stroke or cerebral palsy.

Q: Then your interest in loci of learning is related to a concern with the recovery of functions impaired by brain damage?

A: Yes, but let's first discuss what we've seen in our work with animals, and then I'll try to comment on the possible relationship to human functioning.

Our experiments with neodecorticated cats and rats have suggested that the cortex is not always a good place to look for changes during learning and retention of habits. It has been commonly supposed that the cortex is the main memory bank of the nervous system, but there are indications that deeper structures of the cerebrum are just as important.

Q: How does this relate to the recovery of functioning after brain damage?

A: We see our studies as showing that neural routes can be closed by appropriate procedures, or opened to restore performance otherwise not recoverable. For instance, the research on the effects of amphetamine suggests that some behavioral deficits are not losses of memory, but losses of access to memories after brain damage. Perhaps the language deficits commonly observed following strokes could possibly be treated through drugs, rather than the tedious process of re-educating the patient.

This may, by the way, also explain the "paradoxical" quieting effect of amphetamine when given to hyperactive brain-damaged children. Perhaps the drug helps to ameliorate problems of performance in these children, restoring function to a previously nonfunctioning area.

Q: Would you describe some of the experiments which have led the Meyers to these fascinating theories?

A: Of course. No scientist can turn down an opportunity to describe his—or her—experiments, and how one study grows out of another.

Many of my experiments have stemmed from my dissertation research, which was conducted during the late fifties. In that study, I prepared cats with extensive lesions of the neocortex, which also included removal of large portions of the visual neocortex. The animals, subsequently, were tested on many tasks to assess their visual capacities.

Up to that time, there had been no similar studies at all. Some of the older studies date back to the 1800's, and in the mid-1930's there was Lashley's work.

In that early experiment we learned that after extensive lesions of the cortex, cats could still learn to discriminate light from dark. This was nothing new, and has been shown with various other species. We also found that cats could not learn to discriminate patterns within 500 training trials. This also was not new. The surprise was that the animals could still discriminate the shallow from the deep side of a "visual cliff," which is a laboratory apparatus developed to evaluate depth and discrimination. In this situation, the cats were somehow responding to pattern stimuli, and we asked ourselves how this could occur.

We also learned that the animal could not visually place. That is, if the cat were held in front of a table, it would not extend its forelimbs toward the edge of the table. Surprisingly, though, we found that injections of amphetamine could reinstate the visual placing response. But when the effects of the drug wore off, so

did the ability to place.

Q: Is this what led to the recovery concept in your work?

A: Yes, we then wanted to pursue this line of research with other lesions and drug studies. Since amphetamine induced recovery of *unlearned* responses, we then wanted to determine if recovery of a *learned* response could occur following amphetamine injections. In our experimental situation, normal rats learn a black-white habit in 50 trials. After removal of the visual cortex, it takes them 50 trials again to relearn the habit. Can we help them, we asked, and found we could. If given appropriate doses of amphetamine, the rats can relearn in 30 instead of 50 trials.

So far, so good, we thought. Now for something harder. Can they also relearn a pattern discrimination without their visual cortex? We found the answer is no.

Next, we decided to remove the septal region because with this kind of lesion near the center of the brain the rat can learn some tasks faster than it normally would. We found that removal of the septal area does not facilitate recovery of the black-white habit after ablating the visual cortex, and that the impairment is similar to removing the entire neocortex. Thus, we found that a lesion of the septum does not facilitate relearning a black-white discrimination, as injections of amphetamine has in previous experiments.

Next, we trained rats in a conditioned avoidance situation in a shuttle box, and found that mechanisms involved in facilitated conditioned avoidance response learning are via subcortical routes and not via neocortical routes in the brain.

Currently, we are studying recovery of pattern discrimination in cats with visual lesions by manipulating environmental stimuli. The experiment is being run at the moment and we have no data to report at this time.

Q: It sounds rather like fitting pieces of a puzzle together, and is a clear example of how one study leads to another. Quite another question occurs to us now, perhaps because of the press notice that brain research has been getting lately.

A: In that connection, I'd like to make it quite clear that we are not out to manipulate the behavior of animals to suit our demands. Far from it. We're asking the animal, rather, to tell us by his behavior how his brain works. The main issue of all our research—what it's all about—is how can a lost function be recovered and quickly restored? What neural resources can be tapped in upon so the animal can function again?

I am always surprised by some of the reactions to really essential basic research. What we are trying to do is to learn how normal functions can be recovered so that an animal can operate normally.

Our own program happens to deal with neural circuitry. We want to find out how the brain is tied together so that in case it is damaged we can tie parts of it together which are undamaged so the subject can function normally.

These are not moral judgments. We just want to see how the car operates, not how we can supercharge it or sabotage it. But how can we repair it when its spark plugs get worn out.

Q: Aside from questions the Institute sometimes gets on the need to explore functions of the brain and the effect of brain damage on behavior, concerned citizens inquire as to the use and protection of animals in research studies.

A: On that score, we are very, very particular. We do not believe in sacrificing animals for the sake of conducting laboratory demonstrations. No matter what animal takes part in an experiment, our students are most carefully taught surgical techniques and the best care for the animals with which they are working. The rat undergoes surgery just as a human being. Rats can suffer, too, just like people. We try to stress to our students right from the very beginning that the rat hurts just like you hurt, so you better take good care of them.

Q: All animals at your lab are used only for research purposes?

A: That's right. And all research must be precise and carried out carefully.

Q: To return to our question earlier in the interview about women in science, we were curious as to why you chose the physiological rather than the clinical in psychology, as most women do?

A: Well, I was interested in counseling as an undergraduate, but then I became interested in basic research.

Q: As for being part of a husband-wife team, we often hear that such collaborations frequently favor the male side of the partnership, at least on the practical side. What would happen, for example, if your husband were offered a job elsewhere? Would you then have to leave your present position to follow him to his new post? This is just hypothetical.

A: It's a question that has never crossed my mind, really. We would have no problem in our case. We just go together. I don't think I could do the work without Don. And I don't think he could work without me. To work apart and separately would not be attractive to either of us.

Q: When you are away from your lab, at home, say, do you engage in much shop talk?

A: Usually when we come home we like to talk about other things. As with everyone, we have our hobbies and relaxations. And we have a lovely little daughter Julie who gets along very happily with our sitter, Lucille Taylor, who is a dear part of our family.

As for women's liberation, I do not go for the screaming and yelling part of the movement. I believe that trying to get attention drawn to oneself that way is childish, as I tell my daughter.

However, I believe that women should be trained to enter the field of their choice. As for myself, I believe that by doing the best that I can in my chosen field I am promoting equality for women, which is still lacking.

By doing my own job as well as I know how to do it, and by not discriminating against men, women, black, Chinese, rats, cats, or monkeys —I think that is the best way to practice liberation.

mental health and the law

Civil Commitment of the Narcotic Addict: Evolution of a Treatment Method

David J. Huberty

When heroin was derived from morphine in 1898 it was used as a pain killing medicine. Later it was used to "cure" morphine addiction. However, cure it did not, for the main difference between heroin and morphine is that heroin is three times as powerful and no less addicting. There were in the United States about 264,000 narcotic addicts, many of whom had become addicted because opiates were used as medication. Contract this to estimates of between 100,000 and 200,000 addicts today, almost all of whom have become addicted for psychological reasons. While the estimated number of persons addicted to narcotics has dropped by at least 20 percent since 1900, the reason for the initial abuse of narcotics seems to have changed from abuse as a physical analgesic or painkiller to abuse as a mental analgesic or psychic painkiller.

Perhaps the most important development in decreasing the number of addicted persons was the Harrison Narcotic Act of 1914. This was passed, in part, because of a growing awareness of the numbers of addicted persons. However, the intent of the Harrison Act was to make narcotic drug traffic a matter of record in the U.S. in fulfillment of our agreement under the Hague Conference of 1909, by which most participating nations agreed to limit the production and trade of opiates to what was necessary for medical and scientific purposes. Persons and firms handling drugs were required to register and pay small fees. Violation was punishable by an indeterminate sentence with a 10-year maximum. The Act made no direct mention of addicts despite the influence of drug addiction on its passage.

Judicial interpretation of a statute carries weight and molds direction. The first case to interpret the Harrison Act came up in 1915. In *U.S. v. Jin Fuey Moy,* the Supreme Court ruled that an addict's physician was his only legal source of drugs and that possession of illegally gotten drugs was a violation of the act. *Webb v. U.S.* in 1919 was more restrictive in deciding that it was illegal to prescribe drugs for an addict while not attempting to cure his addiction. Another *Jin Fuey Moy* case in 1920 strengthened *Webb* by stating that a physician could not "cater to the appetite or satisfy the craving of one addicted to the use of the drug." In 1922 the Supreme Court ruled, in *U.S. v. Behrman,* that prescriptions to addicts were illegal regardless of the purpose, even if it was to cure or withdraw the addicted person.

Thus, within 8 years, legal access to narcotic drugs changed from nearly wholesale distribution to everyone to "no sale" to anyone who was an addict or who would prescribe the drugs to an addicted person, regardless of purpose, with one exception—if the addict was in an institution and if the narcotic was given in diminishing doses. Since addicts were generally

not accepted in hospitals, the exception was theoretical, and no legal treatment of addicts was possible.

What was clear in 1922 was that persons addicted to narcotics had to obtain all drugs illegally. Black-market drug traffic mushroomed as persons addicted to narcotics were completely and rather abruptly cut off from any legal supply. Intensifying the crackdown was a 1924 law prohibiting the manufacture of heroin in the United States.

Protests from the medical profession over the *Behrman* decision helped produce a softening of this trend in 1925. The unanimous opinion in *Linder v. U.S.* termed addicts "diseased" and in need of medical treatment. This was a major breakthrough—a medical orientation and a step toward the present-day trend of civil commitment. The decision even suggested the "right to treatment" concept holding that an addict who had been denied medical care by earlier decisions was a diseased person entitled to such care. Despite this interpretation and because of legal confusion in subsequent cases, most doctors and hospitals did not and do not attempt to treat this difficult type of patient.

The Criminal Approach

Prosecutors' and police officers' ignorance of the *Linder* case added to the reluctance to treat the narcotic abuser and supported the alternative available to most communities—incarceration.

In response to *Linder*, to the lack of community treatment facilities, and to the communities' desire to get the addict off the street, legislation was passed in 1929 which led to the construction of two Federal hospitals for treatment of Federal prisoners who were narcotic addicts. The first opened in 1935 at Lexington, Ky., and the second 3 years later at Fort Worth, Tex. These hospitals accepted voluntary patients if space was available. From the late 1930's until the advent of community-based programs in the late 1960's, these two hospitals were the main treatment centers for narcotic addiction in the United States. They are still responsible for the bulk of inpatient treatment of narcotic addicts from every State except New York and California. After 35 years of treating the relatively new illness of addiction, the two centers cite a 90 percent relapse rate and a complementary rate of 10 percent for total cure—measured by complete abstinence.

Supporting the physicians' desire to stay clear of addicts and "let Lexington handle 'em" was the 1934 *Strader v. U.S.* decision which confused the legal status and protection of doctors treating addicts:

> Regulation 85 [of the Federal Bureau of Narcotics] . . . forbids the giving of a prescription to an addict or habitual user of narcotics, not in the course of professional treatment, but for the purpose of providing him with a sufficient quantity to keep him comfortable by maintaining his customary use. Neither the statute nor the regulations preclude a physician from giving an addict a moderate amount of drugs in order to relieve a condition incident to addiction (withdrawal distress), if the physician acts in good faith and in accord with fair medical standards.

The Federal Bureau of Narcotics, created in 1930, was the agency largely responsible for tightening Federal laws, urging State passage of Uniform Narcotics Laws, and making arrests and convictions of addicts easier. Compared to the Bureau, the medical profession was uninterested in narcotic drug abuse, and the Bureau became the leading public policy formulator for the next 40 years.

In the early 1940's there was a drop in addiction, but following the war

the number of narcotic arrests rose. The response was passage of the 1951 Boggs Amendment, which perpetuated the law-and-order view. Besides making it easier to obtain convictions, the Boggs bill changed the indeterminate 10-year-maximum sentence to not less than 2 years and not more than 5 years, with probation permitted on the first offense; a second offense carried a mandatory 5-to-10 years and excluded probation or suspension of sentence; a third offense called for a mandatory 10 to 20 years and excluded probation and suspension of sentence. Most States followed by passing their own version of the Boggs bill.

The 1956 Narcotic Drug Control Act further supported handling of addicts as criminals by providing for harsher and more rigid penalties.

Treatment Frustrations

Until the late 1950's the U.S. Public Health Service was the only expert in treating narcotic addiction. The two Federal hospitals had admissions of 1,000 to over 4,000 patients a year, depending on the number of prisoner-patients serving sentences in any 1 year and the length of stay of volunteer patients.

New treatment methods emerged in the late 1950's, largely out of frustration not only with the narcotic laws themselves, but also with the treatment that was failing to cure the addict. Synanon, the first of many "therapeutic community" approaches, began in 1958 in California. Community-centered projects were active in the early 1960's, primarily in New York City, and often coordinated community social services for followup after detoxification or inpatient psychiatric treatment. While some of these projects enjoyed high success rates, they were and still are highly selective, and it has been argued that they choose the "cream of the crop," thereby making successful treatment a matter of special selection. An equally valid criticism is that the number of addicts who can be treated under these programs is so small that newly addicted persons outnumber those cured in any 1 year.

Changing Social Attitudes

Around this time other developments contributed to the initiation of civil commitment proceedings. The result was a changing social attitude toward the addict.

Spearheading this change was a Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs, which was formed just as the criminal approach was reaching its pinnacle. The ABA had disapproved of the Boggs Act, and was concerned over the punitive direction in handling addiction. Although the AMA had been active before the Harrison Act, it had taken no formal position with regard to the operation of the country's narcotic laws since the mid-1920's, when it opposed outpatient treatment of addicts. In 1954 the New York State Medical Society submitted to the AMA a proposal recommending legalization of the distribution of narcotics to addicts. This prompted the establishment of a special Committee on Narcotic Addiction, whose report called for, among other things, local institutional or outpatient rehabilitation programs, and civil commitment rather than criminal sentence for possession offenses. A summary of this report was included in the Joint Committee's report, *Drug Addiction: Crime or Disease?* From that time to the present the trend has been toward treating the addict as a sick person whose narcotic usage is symptomatic

of his illness. Additional support came from the 1962 White House Conference on Addiction, which prompted political awareness and concern for a change in national policy.

Although professional attitudes were changing, public recommendations lagged at least a decade behind. The present policy of civil commitment reflects the existing professional and public mandate for controlling the conventional behavior of the addict.

Clinical Support for Compulsory Supervision

Clinical support for compulsory supervision of the addict in treatment can be found in recent research. One study investigated the adjustment of 100 male New York City addicts in 1965—12 years after their discharge from inpatient treatment. These were prisoner-patients who had been admitted to the U.S. Public Health Service Hospital at Lexington, Ky., between 1952 and 1953 and released on parole. As expected, 90 per cent returned to narcotic use sometime within the 12-year followup period. However, by the end of the 12 years, 46 percent were drug free and in the community, and 65 percent of these, or 30 percent of the entire research population, had been abstinent for from 3 to 12 years. Also, 67 percent of those who had been in prison for at least 9 months and on parole for a year had been abstinent for 1 year or more. The study concluded that the most significant variable appeared to be presence or absence of constructive but enforced compulsory supervision.

Other research has investigated the use of compulsion and control through the techniques of "rational authority" and "reaching out." Rational authority was described as "providing a firm structuring of the treatment relationship involving the setting of limits, controls, and sanctions through which the acting-out behavior of the addicts could be curbed and minimized." Reaching out included visiting the addict in his home, involving the family, following him into hospitals, jails, and courts, and not letting go until a relationship could be established that would involve him in the rehabilitation process. There was an 80 percent success ratio when reduction in crime was the criterion, a 52 percent success rate measured by employment records, and 71 percent success when conventional social adaptation was the criterion—i.e., sexual and marital adjustment, support of family, and conventional use of leisure time.

Judicial Impetus

The judicial impetus for civil commitment of narcotic addicts was *Robinson v. California.* Robinson, a narcotic addict, had been convicted of being precisely that under a California statute that declared it a misdemeanor to be "addicted to the use of narcotics." The U.S. Supreme Court reversed the conviction on the grounds that punishing narcotic addiction was in violation of the "cruel and unusual punishment" provision of the Eighth Amendment, as well as being a denial of the "due process" clause of the Fourteenth Amendment. However, the court added that even though addiction itself could not be punished as a crime, States could compel addicts to undergo treatment and impose penal sanctions for failure to comply with civil commitment procedures.

The *Robinson* decision offered the judicial support needed to encourage implementation of a California law, enacted a few months before *Robinson,* which provided for civil commitment of addicts for the purpose of

treatment. New York followed suit with similar but improved provisions in 1966.

The civil commitment procedure emerged as national policy when the Federal government passed the Narcotic Addict Rehabilitation Act of 1966. Although it differs from the California and New York statutes in some important respects, such as eligibility and technical procedures, the intentions and methods of implementation are essentially the same. All three programs provide for civil commitment of a narcotic addict to two phases of treatment: inpatient and outpatient. Length of inpatient treatment varies: The California program requires a 6-month minimum; the Federal program, a 6-month maximum after 30 days of evaluation. Outpatient aftercare treatment may last up to 7 years under the California law but only 3 years under the Federal program; it may entail periodic and lengthy recommitments (up to 6 months under the Federal law) to inpatient institutionalization at the treatment centers.

Treatment during either phase may include any or all of the following: individual psychotherapy, group therapy, milieu therapy, vocational and educational rehabilitation, family counseling and other social services. Or treatment may consist simply of parole-type supervision and urinalysis. What constitutes treatment depends in part on the patient's needs as well as his own ability and willingness to involve himself in the program.

Civil Liberties

Some aspects of civil commitment remain unsettled. The courts do not agree on what makes a commitment civil rather than criminal.

For example, in 1963 the California Supreme Court echoed the *Robinson* rationale in denying a habeas corpus petition in *In re De La O*. The petitioner alleged that his commitment was a criminal penalty as evidenced by various "criminal indicia" in the program, including the fact of his confinement. This, he felt, inflicted cruel and unusual punishment in violation of his rights under the Eighth Amendment. The California Supreme Court ruled that the petitioner's commitment was civil in nature, purpose, and effect and that confinement and commitment did not constitute cruel and unusual punishment.

A New York decision views the effect of addict civil commitment differently. In *Matter of James* the State Court of Appeals upheld the addict's constitutional right to remain silent, and his right to counsel throughout the evaluation and commitment proceedings. It reasoned that since the civil commitment of the addict is similar to criminal commitment in depriving him of freedom of action, *Miranda* safeguards are required. *James* reversed an earlier New York decision and rejected the contention that labeling the proceeding as "civil" actually made it so. As in the U.S. Supreme Court's *Gault* decision dealing with juvenile delinquents, the New York court looked at the impact of finding a person to be an addict. Do the social stigma and loss of freedom involved in being adjudicated a narcotic addict indicate that the proceeding is therefore actually criminal in nature?

Another legal issue is the courts' concern and responsibility over what is "adequate treatment." While the Supreme Court did not concern itself in *Robinson* with any minimal level of treatment, the question has been posed in lower-court nonaddict mental-health cases.

Two criteria have generally been

used to resolve the treatment vs. control, right-to-be-treated vs. right-not-to-oe-treated conflict. The right not to be treated is greatly reduced or completely eliminated when the person's act of self-destruction reaches a high life-risk probability. If the "disease" has vast negative social implications or great costs to society, the "sick" person has no right not to be treated. Thus far the social cost of addiction, rather than a genuine concern for the treatment of the individual, has been the criterion most often used in determining whether an addict has a right not to be treated.

Conclusions

- There are more addicted persons in treatment for their narcotic drug problem under civil commitment procedures than under any other single treatment method. Over 13,000 addicts are under civil commitment, compared with about 5,000 on methadone maintenance. Access to comprehensive treatment via civil commitment is relatively easy for anyone who wishes to volunteer under the California, New York, or Federal program.
- The compulsory inpatient-outpatient process provides for a continuum of care formerly unavailable to addicted persons.
- The availability of recommitment to inpatient treatment is likely to result in a shorter run of narcotic usage for those who relapse, thus minimizing risk of physical and psychological harm, economic loss, family deterioration, and imposition of criminal sanctions.
- The treatment programs provide training and experience for professionals. Under the Federal aftercare program, more than 200 professionals in over 100 cities across the country have gained experience in working with addicted persons in the past 3 years.
- While some clinical rseearch is being carried out to determine the success of civilly commited narcotic users, present statistics are limited by the newness of the programs, and tend to vary from month to month and from program to program. The possibilities for clinical research on addiction are now more comprehensive than ever before, as a result of the availability and use of the records of civil commitment programs.
- The social effects of civil commitment include an increased public awareness of what has become an endemic problem to many communities. The approach also fulfills the existing social mandate for some degree of social control of the addict while encouraging a more humane exercise of such control.
- Finally, civil commitment provides a new opportunity for medical, psychiatric, and social treatment—most of which can take place in the addict's home community, where his problem most often began.

Condensed from *Crime and Delinquency*, 18(1):99–109, 1972. Copyright 1972 by the National Council on Crime and Delinquency.

Reprints of original article from David J. Huberty, Director, Narcotic Addiction Treatment, Catholic Social Service, St. Paul, Minn. 55101.

mental health news digests

Inpatient Population Declines in State and County Mental Hospitals

Despite an increase in total impatient admissions in fiscal year 1971—a continuation of a trend over the past 20 years—the number of inpatients in the 321 State and county mental hospitals declined for the 16th consecutive year. The number of inpatients in such hospitals as of June 30, 1971 was 308,024, a 9 percent decline over the past year. Accompanying this decline in inpatient population has been an increase in the number of net releases alive from the hospitals—a trend which began in the mid-1940's. Since 1955 the number has more than tripled, from 126,498 to 418,750 in 1971. For the 2nd successive year, releases exceed admissions. Several factors responsible for this national decline are: more alternate care facilities for the aged, better utilization of outpatient and aftercare facilities, reduction of hospital stay, rise of community mental health centers, better screening procedures, and administrative changes.

Cost per patient day continues to increase and reached $17.59 per patient in fiscal year 1971. Inpatient staff declined slightly in 1971, but due to the decrease in inpatient population, the ratio of full-time staff to resident patients increased—a trend that has been in effect over the years. (From Statistical Note 60, Survey and Reports Section, NIMH)

APA Urges Confidentiality in Insurance Plans' Records

The Board of Trustees of the American Psychiatric Association has stressed that framers of national health care proposals must recognize the urgent need for safeguarding medical records in any national health care system. Records collected in the course of treatment contain intimate and private medical, psychological, and social data which APA feels should *not* be recorded elsewhere and should be used *only* to facilitate treatment.

APA, in addition, insists that data collected for medical research use which is to be computerized and stored be carefully reviewed to protect the identity of the patient and to control data accessibility.

The new position of the APA Task Force on Confidentiality as It Relates to Third Parties proposes that identifiable data be minimal and its availability be confined to carefully selected personnel at the site of treatment. (The full text of the position statement can be found in the *American Journal of Psychiatry,* April 1972.)

Minority Schools Biomedical Support Program

Some 125 4-year colleges, universities, and health-professional schools whose student enrollment is predominantly from ethnic minority groups have been sent applications and guidelines so they may receive support under the Minority Schools Biomedical Support Grant Program sponsored by NIMH's Division of Research Resources. Awards under this program will range from $30,000 to $500,000 per year over a possible 5-year period, and is aimed at bolstering minority biomedical research and training capabilities.

"Pluralistic Assessment Project" Attempts Adaptive Behavior Inventory

The "Pluralistic Assessment Project," funded by NIMH's Center for Epidemiologic Studies, is developing an Adaptive Behavior Inventory for school-age children, based on standardization data on a representative sample of 700 Anglo, 700 Mexican-American, and 700 Black children in the public schools of California. In defining adaptive behavior as a child's ability to interact amicably with others and to cope with increasing societal demands, the Project yields five "spheres" of behavior for evaluation: interpersonal role performance, family role performance, neighborhood role performance, school role performance, and community role performance. Jane R. Mercer, Ph.D., is the Principal Invesigator and June F. Lewis, M.A., is the Project Director at 3393 University Avenue, Riverside, Calif. 92501.

WHO Report on Classification and Evaluation of Mental Health Service Activities

The European Regional Office of the World Health Organization has prepared a second interim report of the Working Group on Classification and Evaluation of Mental Health Service Activities. Subjects covered are the organization and administration of mental health services, mental health service facilities, and manpower resources.

The Working Group, representatives of 18 countries who met in Düsseldorf in November 1970, concluded that the practical application of most data-collection systems for mental health services is limited. Data concerning available mental health facilities and manpower resources is inadequate because of the common practice of evaluating service only when a mishap occurs rather than making on-going appraisals of performance.

The Working Group found that, because of great differences in the data-collection systems of various countries, there was a need to standardize administrative terms used in statistics and health administration in order to make international comparisons. The Group agreed that the insufficiencies in data reporting should not be regarded as failures but as indicators of the need for a more realistic approach to the use of statistics in planning and operating mental health services. It was concluded that WHO would take the initiative in coordinating national studies and arriving at an international terminology.

The report is available on a limited (not for sale) basis from the WHO Regional Office in Copenhagen.

Narcotics Treatment Program in Georgia

The Georgia Narcotics Treatment Program (GNTP) was created last June and now has an active program for treatment and prevention of drug abuse. One of the first steps was a system of walk-in clinics offering methadone maintenance for heroin addicts in Atlanta.

With top priority given to narcotics, particularly heroin addiction, the GNTP planned a system of treatment centers in seven cities in the State. The system now operating in Atlanta includes an intake center, where immediate care is given to any addict who wishes to enter the program, and seven local clinics under the direction of GNTP or in an affiliated relationship. These centers offer a multimodality approach, providing detoxification, main-

tenance and abstinence programs, and rehabilitative services. Clinics have been opened in Macon and Columbus, and Savannah and Augustus will have clinics in operation soon.

In addition to the treatment centers, the GNTP is planning four Atlanta residential facilities. One, Renewal House, is open; another facility will be tied in with a clinic in a predominantly black community, another will be for juveniles, and a fourth is planned for drug users coming out of the State penal system.

The GTNP includes a public drug abuse education program with a Statewide telephone service. Anyone in Georgia can now call a toll-free number (1–800–282–0228) and get information about drugs or help with a drug problem. For people whose information needs are more complex—for example, research scientists needing bibliographies—there will soon be a computer link-up with the National Clearinghouse for Drug Abuse Information.

The director of the program is Peter G. Bourne. (From *Georgia's Health,* March 1972.)

Washingtonian Center for Addictions

A young Boston psychologist received a small grant from the NIMH in 1966 to do research on what therapies are most effective in treating alcoholics. From that study has come the design of a successful hospital-clinic program dedicated solely to problems of alcoholism and drug addiction.

Dr. Joseph Mayer, then Associate Director of an Alcoholism Clinic at the Peter Bent Brigham Hospital in Boston, did a pilot study on why alcoholics' responses vary to different types of therapy—what kinds of patients, under what conditions of treatment, showed what kinds of changes. He gathered information on the family lives, education, health, and employment of 393 patients at the Peter Bent Brigham clinic, and then classified the patients according to levels of social status and personal stability.

Detailed records were kept of the kinds of treatment the patient received; what kind of professional treated them; what medication was used; and what type of psychotherapy or supportive counseling was employed.

It was found that low-status patients tend to show greater improvement when treated by a physician than by a social worker or counselor; psychotherapeutic techniques were more effective with patients higher on the socioeconomic scale. No matter how the patient was classified, the most far-reaching effect was produced by the patient's ability to establish a positive, open relationship with the therapist, and vice versa.

Soon after completing this research, Dr. Mayer was appointed director of the Washingtonian Hospital in Boston; it has now become the Washtonian Center for Addictions. Because low-status, skid-row patients are least likely to improve under traditional outpatient treatment, the formerly private institution has been converted into an open-access, community-based facility. The Center now works with local self-help groups, engages in research, and cares for 2,000 inpatients a year, 70 percent of whom are on welfare.

Mental Health Surveys

A planning project is examining ways to survey a nationwide, representative

sample of the U.S. population to study mental illness, positive attributes of mental health, and ways in which people seek help for mental problems. These surveys will be useful in developing programs for the treatment and prevention of mental illness by providing data on the extent of such illness and the social conditions which may contribute to it.

The first phase will focus on a study of depression, ranging from the mildest symptoms of unhappiness to the most severe depressions including suicidal tendencies. The survey will collect information on the frequency of depression-related symptoms within the general population and compare various social groups. Special attention is being given to finding which depressive symptoms are of concern to people, how such symptoms are related to marriage, family, work, and other life situations, and how depression is related to positive mental health.

The planning study is being done under an NIMH grant by an interdisciplinary team at the Institute for Social Research, Ann Arbor, Mich. 48106.

Plants Used in Folk Medicine

Some medicinal plants used in folk medicine centuries ago and then ignored have been found to yield drugs useful in modern medicine. An example is Rauwolfia whose roots produce reserpine, a tranquilizer and hypertensive agent. A recent study is attempting to find and classify plants used in folk medicine in parts of Texas and Mexico. These plants, believed to be among the first used in medicine on this continent, are now becoming extinct. A survey will be made of both cultivated and noncultivated plants once used in the region for medicinal purposes. Herbal medicines thought to have real medical utility will be sent to researchers for chemical and pharmacological study. The study is being done by Dr. Clarissa T. Kimber, Texas A & M Foundation at College Station, Tex.

Drug Abuse Education and Prevention

"Drugs—A Community at the Crossroads is a new drug education simulation for teacher training and other adult and community programs. The simulation has a Leader's and Director's Guide, 32 Players' Manuals, Role Cards, and other information. It can be played in one period of about 2–3 hours. As in many simulations, roles can be changed—students can play teachers, parents can play administrators, students can play parents, and so on. The simulation package is part of a larger program, called "The Social Seminar," concerned with drug abuse education and prevention. Information may be obtained from the NIMH, Box 1615, Rockville, Md. 20850.

A handbook for law enforcement agencies is being developed by the National Coordinating Council on Drug Education under a grant from the Law Enforcement Assistance Administration of the Department of Justice. The handbook will not focus on law enforcement, but on how law enforcement agencies can be active in drug abuse education and community programs.

The Office of Education is funding seven regional training and support centers for drug abuse education. The centers will train community teams to work on comprehensive prevention programs. An eighth center will be set

up in Washington, D.C. as part of a national training center for drug abuse education.

Conferences

First Annual Radical Psychiatry Conference—The Berkeley Radical Psychiatry Center will host the first annual radical psychiatry conference August 11–13, 1972. The theme of the conference will be "Psychiatric Disturbance as Mystified Oppression." Anyone wishing to submit proposals for 20-minute papers or 2-hour workshops have until July 1 to do so. Send correspondence to Conference Collective, Radical Psychiatry Center, 2333 Webster, Berkeley, Calif. 94705.

Aging Around the World—Dimensions of the Future—is the theme of the Institute of Gerontology's 25th Anniversary Conference on Aging on September 11–13, 1972. The object is to commemorate 25 years of gerontology at the University by assessing what the next 40–50 years hold for older people in this society and others around the world. Leaders from abroad and this country will discuss the effects of a further extension of life, advocacy for and by the elderly, the impact of social change on minorities, the future role of older people in a postindustrial society, older people and the emerging leisure society, and the impact of different kinds of environment on aging life styles. Special features include a program to honor American pioneers in gerontology and a session on a national policy for older Americans. For information write to Wayne Vasey, Co-Director, Institute of Gerontology, 1021 E. Huron St., Ann Arbor, Mich. 48104.

New Publications

A new biweekly publication, *The Advocate for Human Services,* is a newsletter to be published by the National Association of Social Workers. It will report on legislation and pending bills of interest to NASW, giving in-depth analyses of legislative proposals and newly enacted bills. For a free copy write to Paul R. Keys, Editor, NASW Washington Office, 20 E Street, N.W., Washington, D.C. 20001.

The National Aeronautics and Space Administration's new 163-page publication, *Human Factors Aspects of Air Traffic Control,* is now available. It presents an overview of human factors problems associated with the operation and future air traffic control systems, particularly as that role changes as a result of the system's evolution toward a more automated configuration. The publication may be obtained for $3 by writing to National Technical Information Service, Springfield, Va. 22151.

Volunteer Viewpoints is a newsletter to be published by the Office of Education. Disseminated by Volunteers in Education, this publication will be designed for volunteers, school personnel, paraprofessionals, and organizations and agencies that use volunteers in programs. Persons wishing to be placed on the mailing list should write to: Volunteers in Education, U.S. Office of Education, 7th and D Sts. S.W., Room 4614, Washington, D.C., 20202.

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recent nimh publications

Single copies of these publications may be obtained from the Office of Communications, National Institute of Mental Health (Publications Issuance Unit, Room 1B64, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852). A complete list of all publications available from the NIMH may also be obtained from the Office of Communications. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

Mental Health Training and Public Health Manpower. A 254-page book summarizing research findings dealing with public health work, public health schools, their role in training, relevance to health services delivery, and implications for curriculum development. Authored by Stephen E. Goldston, Ed. D., MSPH and Elena Padilla, Ph.D. DHEW Publication No. (HSM) 72–9024. $2.75

Television and Social Behavior. A 6-volume set of reports, produced under the auspices of the Surgeon General's Scientific Advisory Committee on Television and Social Behavior, describes the role of television in contemporary society. The reports focus on the impact of televised violence on the aggressive behavior of children and youth. The six volumes are:

Television and Growing Up: The Impact of Televised Violence. DHEW Publication No. (HSM) 72–9090. $2.25

Vol. I. Media Content and Control. G.A. Comstock and E.A. Rubinstein. DHEW Publication No. (HSM) 72–9056. $2

Vol. II. Television and Social Learning. J.P. Murray, E.A. Rubinstein, and G.A. Comstock. DHEW Publication No. (HSM) 72–9057. $1.50

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Vol. V. Television's Effects: Further Explorations. E.A. Rubinstein, G.A. Comstock, and J.P. Murray. DHEW Publication No. (HSM) 72–9060. $1.50

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